Areawide Planning of

FACILITIES *for* LONG-TERM TREATMENT *and* CARE

Report of the Joint Committee of the American Hospital Association and Public Health Service

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U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Public Health Service
Washington 25, D.C.

PUBLIC HEALTH SERVICE PUBLICATION NO. 930-B-1

February 1963

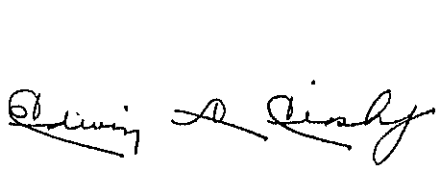
For sale by the Superintendent of Documents, U.S. Government Printing Office,
Washington 25, D.C. - Price 55 cents

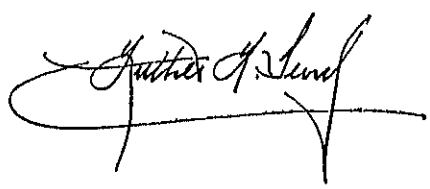
FOREWORD

"Areawide Planning of Facilities for Long-Term Treatment and Care" is the report of a Joint Committee of the American Hospital Association and the Public Health Service. This committee was established as a result of the growing realization of the serious deficiencies in facilities and services for the care of long-term patients, and the necessity for sound planning to meet existing and anticipated needs in a manner consonant with the best traditions of health care in this country.

The committee was appointed and held its first meeting in July 1961. Its charge was to establish principles and make recommendations for use by communities in developing adequate plans for meeting the needs of long-term patients. The committee was asked to consider the extent of needs for services; the current availability and adequacy of facilities and services; the types and organization of facilities necessary to provide adequate treatment, care, and rehabilitation; and the action required to attain these goals.

This report demonstrates the effectiveness with which the committee fulfilled its charge. Its publication provides sound guidelines for areawide planning of facilities for long-term care. The application of the principles and recommendations will do much to assure the future development of a balanced program to meet the health needs of all the people in the Nation.





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GENTLEMEN:

THIS REPORT presents the conclusions and recommendations of the Joint Committee on Areawide Planning of Facilities for Long-Term Treatment and Care. The document culminates a year of study and deliberation on the multitude of problems yet to be resolved in the area of long-term illness. It is submitted in the hope that it will be useful in stimulating needed community action for meeting growing demands for additional and improved facilities and services for care of the long-term patient.

Recommendations in this report reflect the consensus of committee members, each of whom has been directly involved over the years in activities aimed at improving the lot of the long-term patient. Based on this cumulated experience, as well as on the investigations of staff representatives of the two sponsoring groups, the committee has developed specific planning principles and guidelines for community action.

Reports of two earlier committees (the Surgeon General's Ad Hoc Committee on Planning for Mental Health Facilities and the Joint AHA-PHS Committee on Areawide Planning for Hospitals and Related Health Facilities) served as a springboard for deliberations by this group. From the outset, this committee found itself in agreement with the two earlier committees in the underlying philosophy that:

> *The concepts of cooperation and coordination are essential to the planning process—cooperation by both the providers and users of health facilities and services, and coordination of all the health resources appropriate to the various phases of an areawide plan and program.*

As noted in the report of the areawide planning committee, "Areawide Planning for Hospitals and Related Health Facilities," such planning can best be carried out by authoritative local planning agencies comprising both community leaders and those skilled in providing medical care and related services. Since many of the services needed by the long-term patient are similar to those required by other types of patients, it is important that the entire spectrum of health facilities be considered during the planning process.

This report does not attempt to offer a simple solution to the many pressing and perplexing problems of long-term patient care. The committee hopes, however, that the proposed principles and guidelines will lead us one step further toward better planning of facilities and services for the increasing number of persons in our population—particularly those in the middle and later years—who are afflicted with long-term illness.

Ray E Brown

JANUARY 1963. RAY E. BROWN, *Chairman.*

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THE CRITICAL shortage of adequate and well-coordinated facilities and services for long-term treatment and care has emerged as one of the major health problems of the present decade. Factors contributing to this growing problem include:

1. The increasing prevalence of chronic disabilities and long-term and degenerative diseases in all age groups, which is accentuated by the growing number of the elderly in our population, with their greater proneness to chronic illness, higher incidence of multiple impairments, and greater severity of disability.

2. The failure of community planning and organization for health care to keep pace with the changing needs of our population. Although a wide variety of new services and agencies have emerged, few attempts have been made to develop comprehensive patterns of treatment and care within coordinated community health programs.

3. The growing obsolescence of our existing facilities and programs, emphasized by the recent advances in medical science, which now make possible new and more effective approaches to the treatment, care, and rehabilitation of long-term patients.

If the increasing demands for more appropriate long-term facilities and services are to be met, coordinated areawide planning is essential.

COMMITTEE OBJECTIVES

IN DEVELOPING the present report, the committee established three primary objectives:

1. To describe and evaluate current patterns of use of long-term care facilities.

2. To outline an organized approach through which needed facilities and services can be provided.

3. To develop guidelines for use by national, State and local groups in planning for long-term care facilities and in promoting coordination of health facilities and services.

Throughout the study, emphasis was placed upon the specific needs of the patient as the primary focus of interest in planning for both facilities and services.

PLANNING GOALS

THE FUNDAMENTAL goal of planning for long-term patient care is the development of a comprehensive and coordinated pattern of services to meet the many and varied needs of

chronically ill and disabled individuals. In terms of facility planning, achievement of this goal involves:

1. Providing for a sufficient number of high quality facilities with a full range of needed services.

2. Promoting flexibility of design to facilitate maximum utilization of resource

3. Integrating these facilities into a comprehensive pattern of services.

4. Developing cooperative arrangemen to promote high quality of care and op mum efficiency and economy in use of co munity resources.

Patient Needs

Long-term patients have a wide variety of chronic illnesses and disabilities. While their primary needs for service are not fundamentally different from those of acutely ill patients, the distinctive characteristics of long-term illness require that the *long-term patient* be viewed *not only as an immediate medical problem but as a total* person whose long-range needs for services extend beyond direct medical and *nursing care.*

In general, the needs of long-term patients *may be* grouped into the following categories:

1. Preventive services, *including both primary and secondary prevention.*

2. Patient management, involving medical and social evaluation and treatment and the provision of nursing, supportive, personal, an protective care.

3. Restorative services.

The organization of services within a specific community will depend upon the extent o need and the availability of resources. Services may be provided on a specialized basis i separate facilities or in *combinations of several* types of services in a more generalized facility. The complex of facilities and services necessary to meet the needs of the long-term patient includes nursing homes or units providing skilled nursing services, facilities for custodial and sheltered care, outpatient clinics, and organized home care *programs,* as well as the diagnostic *and intensive* treatment services of an acute general hospital.

Current Resources

Services for long-term patients are currently provided in a wide variety of facilities, including specialized units of general hospitals, institutions for treatment of mental illness or tuberculosis, and an increasing number of rehabilitation centers and hospital departments of restorative medicine. The growing demand for service to patients who do not require the specialized services of a hospital has resulted in the development of a wide range of facilities designated as nursing homes, convalescent homes, and homes for the aged. Services provided by these facilities range from skilled nursing care to personal services and sheltered care.

For those long-term patients who would not need extended institutional care if services outside the hospital were available, *home care* services of some type have been established in many areas. However, only a few communities have developed the type of coordinated home care programs—characterized by central administration and coordination of *medical, nursing,* social and related services—that might improve utilization of existing resources.

Current Deficiencies

Facilities and programs for the long-term patient have, for the most part, developed in an uncoordinated fashion, primarily in response to demands for specific types of service. As a result, most facilities are presently organized to provide only limited services.

Lack of adequate controls over programing and construction has permitted the overbuilding of certain types of facilities, with consequent duplication of services and uneconomic operation. Inadequate licensure standards and enforcement procedures, and the continued utilization by welfare agencies of substandard facilities, have further contributed to the problem.

Orderly plans are needed for financing the construction and operation of facilities and for paying for services. The development or extension of third-party payment systems to provide adequate payment for long-term services is essential.

Improved staffing standards, better utilization of available personnel, and better personnel policies are necessary if the present patterns of service are to be upgraded.

Emerging Patterns

Acceptance of their expanding role in the field of chronic illness has stimulated a number of general hospitals to organize chronic care units and to develop and administer coordinated home care programs. Services necessary for more comprehensive programs of care are being added by the more progressive hospitals, nursing homes, and homes for the aged. Some facilities for the aged are being designed to provide the multiple services needed for the chronically ill.

In some communities, day or night care facilities have been developed, particularly for the mentally ill but also for other chronic patients, to provide a transition between the hospital and community life. Other noteworthy developments include the increasing recognition of the benefits to long-term patients of restorative treatment, and the resulting increased emphasis placed by hospitals and other medical care facilities on programs of restorative therapy as well as preventive services.

Principles for Areawide Planning

The variety of services required for an effective program of treatment and care, and the impact of long-term beds on the need for acute beds, demand that programing of facilities for the chronically ill and aged be closely related to other planning efforts in the community service area. Responsibility for planning for long-term facilities should be vested in an areawide planning agency broadly representative of and in close contact with community interests and organizations concerned with the problems of health care.[1]

Members of the governing board of the planning agency should be drawn from the top echelon of community leadership. While the majority of the membership should not be engaged full time in health or hospital work, it is essential that representatives of the health field be included on the governing body, or as members of advisory committees, to give techni-

[1] For a more detailed discussion of the organization, recommended composition and responsibility of an areawide planning agency, see *Areawide Planning for Hospitals and Related Health Facilities.* (Item 16 in appendix C, Selected Bibliography.)

cal guidance. The planning group should have the endorsement of the State Hill-Burton agency, and it should have sufficient authority to develop a plan and to report directly to the community. The program of such an agency should include plans to meet the needs for all types of health care facilities, with due regard for their relationships to each other.

The agency should be a continuing organization which will work toward developing community support, including financial, for its ongoing activities and, finally, it should recognize its responsibility for the implementation of the programs developed.

To aid areawide planning groups in planning and programing long-term care facilities, basic principles were developed which, in general, may be considered in terms of scope of planning, cooperative relationships, and optimum use of facilities and staff.

Scope of Planning

Principles relating to the scope of planning reflect the need for a wide gamut of facilities and programs, including preventive treatment and rehabilitative services for the long-term patient. Home care and community health programs, as well as services provided by hospitals and other types of facilities, are among the planning aspects considered in the principles which follow:

Planning should include the entire complex of facilities and services for the long-term patient.

The concept of preventive and restorative care should be incorporated in all long-term treatment programs.

Home care services should be an integral part of areawide planning for facilities and services.

Programs for supervision and maintenance of health of persons residing in homes or housing for the aged are essential elements of areawide planning for long-term care.

Community programs for early detection, treatment, and rehabilitation of persons with mental illness should be an integral part of areawide planning programs.

The need for tuberculosis facilities and programs should be considered as part of planning for long-term care.

Cooperative Relationships

The importance of developing cooperative working relationships among facilities and programs is emphasized by the following principles, which relate to such matters as formal agreements between institutions, continuity of care, accessibility of facilities, and proper patient placement:

The general hospital and its organized medical staff should accept responsibility for providing long-term treatment and care, either through the construction or allocation of its own facilities or through relationships with one or more established facilities.

Facilities and services for long-term care should be coordinated through formal agreements.

Facilities should be organized to promote continuity of patient care.

Physical transfer of long-term patients should be minimized.

Facilities for long-term care should be so located that the services of an organized medical staff are readily accessible.

Optimum Use of Facilities and Staff

Important corollaries to optimum use of facilities and staff are high quality of care and efficient operation. Thus, the following principles may be considered in this category:

Existing community resources should be utilized at maximum efficiency.

Patient placement should be in accordance with need for service.

Higher quality of care should be promoted through the development of programs of education and training.

Planning for long-term care facilities and services should be based on patient needs rather than on the availability of funds.

Programs of research and continuing revaluation should be established as guides for continuing development of the planning process.

Other Principles

The remaining principles relate to a wide range of subjects, such as the need for data collection, responsibility for planning, improvement of licensure standards, and a more equitable distribution of community funds to long-term care facilities. They include:

Planning for long-term care facilities should be based on detailed knowledge of the population group to be served and its needs for various types of services.

Planning of facilities both for short-term acute and for long-term treatment and care should be undertaken by the same areawide planning agency.

The areawide planning agency should encourage the adoption and use of standards for construction, maintenance, and operation, as advocated by recognized national authorities.

Fund-raising groups should be encouraged to make a more equitable distribution of their funds to long-term care facilities and services.

Overcoming Obstacles

Potential obstacles to the achievement of desirable areawide planning goals must be identified and evaluated so that appropriate actions can be initiated to minimize or offset their influence. Areas of concern include:

1. ***Limited availability of financing either for capital construction or for costs of operation.*** Existing sources of funds for capital construction, both public and private, should be investigated and appropriate action taken to develop new or improved patterns of financing.

Revenue for operating long-term care facilities is derived primarily from direct patient payments and from tax funds. Increased appropriation from government sources at all levels for welfare and public assistance programs is necessary if desirable levels of service are to be attained.

2. ***Lack of adequately trained personnel.*** Shortages of qualified personnel are particularly pronounced in the long-term care field. Need exists for improved personnel policies and programs, including active recruitment programs, better working conditions, higher personnel standards, and inservice programs aimed at more effective utilization of available personnel.

3. ***Organizational, administrative, and regulatory problems.*** Existing patterns of organization and administration of facilities and programs, involving diversified sponsorship and fragmentation of responsibility for patient care, may impede the development of desirable, well-coordinated programs of patient services. Similarly, inadequate licensure requirements and the acceptance of low standards of performance may present problems which must be resolved before desired program objectives can be attained. Development of close collaborative relationships with other planning groups and with the State Hill-Burton agency will help to prevent conflict in purpose and wasteful duplication of effort.

4. ***Existing social, cultural, and professional attitudes toward long-term care.*** Public support of long-term care programs reflects public attitudes toward the problems of chronic illness and disability. In some areas, long-term facilities and programs have been developed on a cultural, religious, or other group basis, with consequent variations in the nature and quality of the services being provided. Extensive community education programs are needed to develop an awareness of these problems and to stimulate wider appreciation of the service needs of this population group. Physicians and hospital administrators, in particular, should be encouraged to assume major roles in planning and organizing long-term services.

Developing and Implementing the Areawide Plan

The adequacy of a proposed program for long-term patient care will depend upon the degree to which sound procedures of planning and implementation are followed. Essential aspects of the planning process include:

Recognition of the existence of an areawide problem.

Organization of an areawide planning agency.

Data gathering and analysis.

Identification of planning objectives.

Establishment of standards and criteria.

Stimulation of individual organizations and agencies to self-evaluation and planning.

Review of planning proposals and phasing of programs.

Periodic followup and revaluation of planning determinations and the resulting programs.

Proposals for Action

Conclusions derived from detailed analyses of data and review of problem situations will provide a basis for developing a plan and proposals for action. Planning recommendations should be based on realistic standards and criteria relating both to suitability of physical structure and efficient provision of services. Professional review committees should be established to review and advise on policy and planning determinations.

Involvement of Related Organizations and Agencies

Each institution and agency in the area concerned with problems of long-term care should be encouraged to study the findings and proposals of the areawide planning agency, to define its specific community role, and to develop individual programs and plans. Local community hospitals in particular should be urged to assume a major role in the proposed pattern of long-term services. Efforts should be made to enlist the cooperation of local physicians and local health and welfare organizations, and to develop cooperative relationships with State Hill-Burton, mental health, vocational rehabilitation, and tuberculosis control programs.

Review of Proposed Action Programs

Proposals for construction or development of facilities should be reviewed in accordance with established criteria. Projects not conforming to program objectives should be discouraged. Acceptable proposals should be

endorsed through formal approval action and public announcement. Wherever indicated, projected facilities and services should be phased on the basis of immediate and long-range community needs.

Followup and Revaluation

The planning agency's responsibility includes active assistance to sponsors of new construction through continued consultation, assistance in fund raising, and stimulation of public support. In addition, continuing support should be given to publicity and education programs, to efforts for improving licensure standards, and to developing more adequate State and local financing of services to long-term patients.

Planning should be a continuous and dynamic process. Procedures should be established for periodic revaluation of areawide needs, of existing plans, and of programs in operation. As new situations develop, current plans must be modified to meet changed needs or to develop more appropriate patterns of patient care.

Chapter II

Long-Term Patients and Their Needs

LONG-TERM PATIENTS include individuals who, because of their physical or mental condition, require medical, nursing, or supportive health care for a prolonged period of time. Among those needing such care are patients requiring extended periods of convalescence or treatment as a result of severe illness or injury. These conditions are not confined to any specific age group. Although chronic diseases occur more frequently in middle-aged and older persons, the importance of the problem of chronic illness or disability among children and young adults is being increasingly recognized.

Many chronic diseases are characterized by spontaneous exacerbations and remissions. In older patients, the long-range outlook is more likely to be one of gradual diminution of function. Although this process can be modified by proper treatment, the characteristic of functional loss distinguishes the elderly patient from the young person in whom one can more frequently anticipate restoration of normal or near-normal function. While, in general, the prognosis for younger persons is more hopeful, there are certain important exceptions: (1) chronic progressive neurological disorders, such as multiple sclerosis, which characteristically occur in young people; (2) irreversible congenital defects, such as cerebral palsy; or (3) certain severe injuries, such as those of the spinal cord, which result in irreversible damage.

Despite the wide variation in the causes of chronic illness and disability, and in the age group affected, there is one common denominator: the need for care over a prolonged period of time. The amount and kinds of services required for the chronically ill, and even for the same individual over a period of time, may vary widely, depending upon: (1) the nature and intensity of the illness or disabling condition; (2) the patient's potential for restoration of function; (3) the availability of techniques for treating the particular condition; (4) the probability of spontaneous exacerbations and remissions characteristic of the particular condition or related to the patient's response to treatment, and (5) the patient's reaction to illness and disability.

The medical needs of long-term patients are not fundamentally different from those of patients with acute short-term illness or injury. The major difference lies in the duration and variability of the care needs and the greater probability of an ultimately reduced level of functioning.

In general, both the acutely ill and the long-term patient require similar primary services, even though these services may be utilized in differing amounts and frequency, and even with different objectives.

Both groups of patients need medical examination, evaluation, diagnosis, and definitive treatment as well as access to facilities in which these complex services can be provided. Adequate provision of these services may require the involvement of several or all of the following: family physicians; specialists in such fields as internal medicine, surgery, pediatrics, anesthesiology, radiology, pathology, physiatry, and psychiatry; and a variety of paramedical personnel such as nurses, dietitians, physical therapists, occupational therapists, and social workers.

The difference between the needs of patients with acute self-limiting illness and those with a chronic condition or disability begins to emerge in the postacute phase of illness, after the immediate objective of establishing diagnosis and instituting definitive therapy has been met. The acutely ill patient can usually

look forward to a brief convalescence and early return to his normal way of living. The patient with a chronic condition requires continuing medical supervision and guidance. This may involve a therapeutic regime, such as the physical therapy which assists a stroke patient to achieve maximum restoration of function, or may be limited to assistance with such basic needs of daily living as adequate diet, safe shelter, and personal hygiene.

In any event, the impact of his illness is likely to interfere with the patient's normal living pattern for an indefinite period of time, often for the remainder of his life. Because of the frequent need for multiple services, a coordinating mechanism is essential, not only for care in the hospital but also for care outside the hospital. Particularly in those instances where effective function is not seriously limited by the chronic condition, the availability of these services, on a coordinated basis, would enable many patients to maintain themselves either through their own efforts or with the assistance of family or friends.

To illustrate the broad range of problems faced by the chronically ill or disabled, several hypothetical "case histories" are presented. These exemplify the needs for coordinated services by different types of long-term patients, including: a young patient with a serious injury which appears to be only partially remediable; a young or middle-aged patient with an intermittent but progressive disease; and an elderly couple able to manage in their own home until injury struck one and disrupted both their lives. Two of the cases are examples of long-term patients who started their treatment during an acute episode.

Case I

Linda S., an 18-year-old high school senior, was in good health until injured in an auto accident which resulted in a vertebral fracture with spinal cord injury in the upper thoracic region. She was treated at the local general hospital, but it was evident after surgical exploration of the spinal fracture and several weeks' observation and treatment that she would be unlikely to regain any voluntary control of her lower extremities, bladder, or bowels.

She has been transferred to a rehabilitation facility where the outlook is for a period of many months of highly specialized treatment to enable her to achieve maximum adaptation to her limitations. She will require use of a wheel chair and braces for the remainder of her life. Emotional adjustment and vocational training and placement will be of high importance, and continued access to expert medical supervision will be essential because of residual conditions such as the orthopedic and urinary problems.

The length of time spent in the rehabilitation center will depend to a considerable extent on her home situation, the availability of transportation to and from the center as an outpatient, the availability of financial resources for continued care and retraining, and the ability and willingness of her local physician and family to accept responsibility for an extensive program of treatment.

Case II

Mr. L. is a 45-year-old machinist. About 15 years ago, he had an episode of weakness of both legs for which he was hospitalized for diagnostic studies. As his hands were unaffected, he was off the job only a short time. During the past 10 years he has been out of work almost half of the time, with repeated episodes of weakness, paralysis, numbness, and tremors, affecting one or more of his limbs. He has had three hospital admissions for periods varying from five days to two weeks, and since the last admission, he has been confined to a wheelchair because of almost complete paralysis of his legs.

Three months ago, because of repeated episodes of painful cramps in his legs and increasing loss of bladder control, his wife sought to have him admitted to a hospital. However, his doctor said that the hospital could do nothing for him and advised admission to a nursing home. After six weeks in a nursing home, Mr. L. was anxious to return home; with part-time

help, Mrs. L. has managed his care, and has even noted some improvement.

Unfortunately, the nature of Mr. L.'s disease, multiple sclerosis, is such that the outlook is for increasingly severe and prolonged episodes, with cumulative disability and ever greater care requirements. In the absence of a good home care program, early admission to institutional care may be required, despite Mrs. L.'s efforts to care for her husband at home.

Case III

Mr. and Mrs. K., aged 75 and 73, respectively, have lived in a second-floor walkup apartment for many years. Both are "in good health for their age," although Mr. K. has diabetes, first diagnosed at age 70, and requires a small dose of insulin daily.

Mrs. K. tripped on a scatter rug and fell, fracturing the neck of her left femur. She was taken to the nearby medical center for immediate treatment on the orthopedic service, including surgical pinning of the fracture.

Medical examination during the hospital stay revealed a considerable degree of generalized arteriosclerosis with limited cardiac reserve, fairly severe degenerative arthritis of her fingers and wrists, and hypochromic anemia believed to be of nutritional origin.

After 2 weeks on the orthopedic service, Mrs. K.'s wound was healed, the fracture was in good position, and she was up in a wheelchair daily and beginning to use a walker. However, inactivity had caused stiffening of finger and wrist joints and physical therapy was needed before she could manipulate any type of aid to walking. Medical evaluation of her cardiac condition and anemia had been completed and treatment started. The orthopedic service was ready and anxious to discharge her as a bed patient. However, since the hospital had no long-term care unit, she remained on the orthopedic service for an additional 4 weeks until a bed was available in a nursing home providing the type of continuation care required.

By the time she entered the nursing home, Mrs. K. was doing a little walking with the walker without bearing weight on her injured limb. She still requires physical therapy for her injury and occupational therapy to maintain function in her hands. She also requires medical and dietary supervision. Special transportation is required to bring her to the hospital outpatient department for orthopedic and X-ray followup. In the absence of assistance in housekeeping and personal care at home, she will need institutional care for several months, but may later return home if a ground floor apartment can be found in a convenient location.

Meanwhile, with Mrs. K. in the hospital, Mr. K. had neglected his diet and insulin. A neighbor found him obviously confused and disoriented. Fortunately, Mr. K. carried a diabetic card including the name of his doctor, so the police phoned the doctor's office and were advised to take him to the hospital.

With a few days of adequate diet and insulin, Mr. K.'s confusion cleared, and after a week of hospital care he was ready for discharge. To manage at home without his wife, however, he would have required home nursing visits (daily, at least initially, to check urine and to supervise the administering of insulin), homemaker service or Meals on Wheels, and periodic transportation to his doctor's office. Since these services were unavailable, the only alternative was a nursing home where his physical needs could be cared for. He soon lost interest in his surroundings, however, and began to fail rapidly, both physically and mentally.

By the time Mrs. K. is able to go home, her husband will probably require more care than she can provide, so he is likely to be in an institution for the remainder of his life, unless, through coordinated planning, the needed treatment and services can be brought to him in his home.

The preceding case histories emphasize the urgent need for (1) comprehensive, coordinated community services, and (2) planning for long-term care facilities. More subtly, they confirm the present lack of certain services, or proper quality of services, to give the care needed by these patients.

Between the lines of these case illustrations can be read underlying need for health education, counseling, adequate diagnostic and preventive medical care, retirement preparation, housing, homemaker service, central referral services and financial provision for such services. Such services, had they been available, could have prevented or minimized certain conditions described in the foregoing case stories. To alleviate such human suffering and prevent or postpone institutionalization, planning of facilities for long-term care must include exhaustive exploration of all community services presently available, and assure their availability in the future.

Range of Needed Services

The usually insidious onset of long-term illness, the extended period of incapacity, the need for continued medical supervision, and the probability of residual disability underscore the fact that the long-term patient needs a wide range of organized services which extend beyond direct medical and nursing care. For a specific individual, these needs may arise in combination or in sequence, with considerable variation according to the complexity and intensity of the disabling condition.

The needs of the chronically ill vary from patient to patient and, for any one patient, change from time to time. The frequency and rapidity of change is unpredictable; the need for intensive care, for example, may arise suddenly, and may last for varying periods of time—brief, intermittent, or prolonged. The variation and unpredictability of need have significant implications for the method of organizing and coordinating the wide range of needed services.

Another significant variation affecting service needs is the extent to which patients can assume responsibility for their own care, and the extent of participation that can be expected from family members. Adequate understanding of the treatment program and its objectives by the patient and his family, achieved through a planned educational program, is essential to ensure their cooperation and participation. The teaching function may be the primary responsibility of one professional individual, such as the public health nurse, but is also inherent in the responsibilities of each member of the health team in his relationship with the patient and his family.

The services needed by long-term patients may be grouped into the following classifications:

Preventive Services

Primary Prevention.—Primary preventive measures are as important for the ill as the well. Because of the lowered physical resources of the chronically ill and aged, susceptibility to other illnesses is increased. For example, recurrent attacks of rheumatic fever increase susceptibility to rheumatic heart disease; prophylactic treatment with antibiotics is an essential primary preventive measure. Another example of primary prevention for persons already ill or disabled is accident prevention. Because of impaired function, such individuals are more accident prone than well individuals. Primary preventive measures for arthritic or stroke patients and amputees who have difficulty in ambulation include good lighting in the home or the institution and the installation of safety devices such as grab bars.

Secondary Prevention.—Early detection of chronic diseases is of prime importance in preventing further deterioration and complications. While this type of prevention is most frequently considered in connection with screening programs for apparently well individuals, it is equally important that there be close observation of the individual who is already ill.

The long-term patient should be thoroughly re-examined at regular intervals, not only to

determine the status of the known chronic illness but also to detect any new condition in its incipient state when remedial action may be taken. The stroke patient, for example, may have incipient diabetes, glaucoma, or pernicious anemia which could be detected while he is under intensive care for the known disabling condition.

Patient Management

Medical and Social Diagnosis, Evaluation, and Treatment Plan.—Care and treatment of the long-term patient should be based on a full diagnostic evaluation, so that the therapeutic program can be geared to the patient's total medical and social situation. This is particularly true of the elderly patient, because of the probabilty of mutiple chronic conditions and their influence on each other. An important part of this evaluation is the determination of the strengths or weaknesses of the family structure and of family attitudes toward the patient and his illness.

Prevention of Disability.—Patient management should include measures during the early acute phase of chronic illness, to minimize, delay, or even prevent secondary disabilities. Such preventive measures as proper positioning in bed, prescribed exercises, and early ambulation are important aspects of care during the early phase of many chronic conditions, and may, under appropriate circumstances, be carried out by family members under the direction and supervision of professional personnel.

The chronically ill patient may suffer from many unnecessary complications because of having been immobilized following the clinical onset of disease. Improper or prolonged immobilization may lead to atrophy of muscles, contractures, stiffness and soreness of joints, incontinence, and bedsores. The resulting loss of function may be permanent, or the patient may require prolonged treatment to restore the damaged function.

Nursing, Supportive, Personal, and Protective Care.—Many individuals with long-term illness or disability reach a relatively stable plateau during which their needs may be only for supportive services, under medical direction, to maintain the achieved stability. This may involve continuation of the simple measures described above, as well as assistance in walking, getting in and out of bed, bathing, help with dressing or feeding, special diets, and supervision to assure that the patient's activities are sustained but do not exceed his abilities. Other patients will need nursing services that can be provided safely only by professional nurses or under their direct supervision. These needs may include full bed baths, enemas, irrigations, catheterizations, application of dressings or bandages, administration of medications (including parenteral injections), and other prescribed treatments requiring skill in administration. Another group of patients will need only shelter care—housing, food service, laundry, and occasional help with personal and legal affairs. For such individuals, a protected environment is the primary need.

Restorative Services

Services planned to minimize the degree of disability and to maintain or restore the individual to the highest attainable level of function are essential elements of an effective program of long-term care. Full use of these services, even when available, is too often neglected because of negative attitudes of professional personnel toward elderly persons who cannot hope to achieve full restoration of function or to attain vocational goals. Achievement of self-sufficiency in the activities of daily living, though a limited objective, may spell the difference between a reasonably independent existence at home and helpless dependency in an institution.

A significant amount of needed services can be provided through a relatively simple and inexpensive program of restorative medicine. Many disabled persons, however, will need the complex medical restorative services, the social and vocational assessment, and the retraining programs of a rehabilitation center.

Essential Elements of an Adequate Pattern of Services

Long-term care services are currently being provided in a variety of ways, ranging from a number of separate, specialized facilities and programs with little or no interrelationship to the comprehensive medical care center with the full range of services under one centralized administration. An adequate program of long-term care demands the coordination of facilities and services, not only to achieve continuity of care but also to prevent the several components from remaining static because of isolation. The types of facilities and programs needed for an adequate pattern of services include:

● ***A modern general hospital with a broad philosophy of service.*** In addition to essential medical and nursing specialties and services, there should be adequate facilities and personnel for rehabilitation, including such services as physical therapy, occupational therapy, social casework, and recreation. The primary function of such a hospital is to provide appropriate facilities for definitive diagnosis and/or treatment. Patients with complicated conditions beyond the range of the resources that can be efficiently provided within the area should be referred to those few specialized centers in the country equipped to meet their needs. Patients requiring less extensive services should be cared for in a facility geared to their needs, or in their own homes.

● ***A long-term care institution or unit providing skilled nursing service for convalescent or chronically ill and infirm patients who no longer require the intensive medical procedures of the hospital but who still require skilled nursing under medical supervision.*** To assure ready availability of medical care and medical supervision, this facility should be a part of or closely affiliated with a general hospital. To the extent feasible, this type of facility should include a program of restorative services designed to develop and/or maintain maximum patient capability. As a minimum, services should be sufficient to maintain function even for patients with very limited potential.

● ***Facilities providing a protected environment and personal care to individuals who do not require acute medical care, but who, because of mental or physical disability or handicap, need extensive assistance in meeting their daily needs.*** Skilled nursing services may be needed from time to time by some of these patients. The medical care program should be under the direction of a physician, and there should be a close working relationship with a nearby general hospital.

● ***Facilities providing shelter care for those individuals with relatively minor chronic involvement or infirmity who, primarily because of social or economic considerations, are unable to maintain themselves in the community.*** While basic emphasis is on food, lodging, and personal needs, some supervision and personal assistance are required in the activities of daily living. Medical supervision and periodic medical evaluation may be provided either in the facility or through arrangement with outpatient services of nearby hospitals, or with home care programs.

● ***Programs of home care for the chronically ill and disabled who do not require the specialized resources of a hospital or the constant care and supervision of an institutional program.*** With varying degrees of medical and nursing care, along with social, recreational, and housekeeping services, these patients can be maintained in their own homes. Program emphasis will depend upon the nature and degree of illness or handicap and the availability of outpatient services. The services needed by patients in their homes may range from simple homemaking services and home aids to relatively close medical and nursing supervision and care.

● ***Outpatient services for diagnosis and treatment of ambulatory patients who are***

able to travel from their homes to a treatment facility. These services should be a part of or closely affiliated with a general hospital and should be coordinated with appropriate programs of social service and home care designed to maintain the individual in his own home as long as medically and socially feasible.

The appropriate stay in any of these settings should be determined solely on the basis of the patients' need for service. Proper patient referral requires a comprehensive evaluation of the individual's medical, economic, and social circumstances, including the extent to which the family is able to meet the patient's needs and the availability and quality of services. Recommendations for placement, following the acute phase of illness, should reflect a team assessment of the patient as a whole, involving the combined judgments of a physician, staff or visiting nurse, rehabilitation specialist, therapist, and social caseworker.

The need for preventive and maintenance services underlies all aspects of an effective long-term care program. Responsibility for care of the long-term patient includes an obligation to provide for early diagnosis and prompt, comprehensive treatment of the whole patient to prevent or postpone deterioration and complications which may produce or aggravate disability.[1]

Inherent in the concept of early diagnosis and treatment is the need for continuing medical supervision; periodical physical, functional, and social assessment of the individual; early provision of appropriate therapies; and established procedures for easy referral. For patients already under medical supervision, primary responsibility for prevention of onset or aggravation of illness or disability rests with the attending physician. Additional resources, both for carrying out prescribed programs of therapy and care and for new casefinding, include: hospital outpatient departments and organized clinics; offices of private practitioners; casework programs; and counseling and referral services.

Needed services should be readily accessible to all patients, though not necessarily within the same institution. The concept of availability of services in accordance with recognized patient needs requires that existing and proposed facilities be closely coordinated within an areawide pattern of service.

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[1] Commission on Chronic Illness. *Chronic Illness in the United States*, Vol. 2, "Care of the Long-term Patient," p. 423. (Item 1 in appendix C, Selected Bibliography.)

Chapter III

Current Resources and Emerging Trends

CURRENT PATTERNS of care and treatment of the long-term patient encompass a wide variety of resources. These include both institutional and out-of-institutional programs and services. While some basic services and facilities for long-term care are available in most communities, wide variations exist in the quality and quantity of the services provided. For the most part, the nature and availability of services depend upon community recognition of needs and the extent of financial support.

Changing concepts of treatment and care of the long-term patient emphasize the need, in many areas, for a more effective arrangement of services and the development of new programs of prevention, treatment, and rehabilitation. Emerging patterns of treatment and care are, to a greater extent, community oriented and show an increased recognition of the expanding role of the general hospital in the treatment of the chronically ill and disabled. Although more and more medical centers are broadening the scope of their services, new concepts of organization and use of community resources are urgently needed.

EXISTING INSTITUTIONAL FACILITIES AND SERVICES

INSTITUTIONAL CARE of long-term patients involves, to some degree, the entire complex of hospitals and related health facilities. More specifically, facilities for long-term care include chronic disease units of general hospitals, chronic disease hospitals, nursing homes, homes for the aged, mental and tuberculosis hospitals, and rehabilitation facilities. (See appendix D, Glossary of Terms, p. 80.) While precise knowledge of the extent to which long-term care is being provided nationally is lacking, data currently available by geographic areas indicate that there are wide variations in the quality and quantity of long-term care facilities.

General Hospitals

Most general hospitals do not provide specialized accommodations and services for the chronically ill. However, National Health Survey data indicate that during 1958–60 more than one-fourth of the total hospital days for patients discharged from short-term general hospitals represented stays exceeding one month. (See table 7, appendix A.)

In the absence of an organized treatment program for long-term patients, their special needs are likely to go unmet in an institution with services geared primarily to care for the acutely ill. As a result of the rapid growth of this segment of the hospital population and of advances in medical techniques, an increasing number of general hospitals have established specialized units for the treatment of the chronically ill. Some have developed nursing home facilities for extended care as a component of the hospital's total service. These developments stem partly from recognition of the advantages to chronic patients of a planned program with ready access to organized medical

services and from an awareness of the economic advantages of specialized treatment units. Additional impetus has resulted from the greater availability of financial assistance from Federal and other sources for the construction of such units.

Chronic Disease Hospitals

Specialized hospitals for the treatment of chronic illness have long been accepted as a part of the pattern of long-term care. In addition to providing an organized medical staff and the definitive diagnostic and treatment procedures otherwise available only in the general hospital, these facilities offer continuing care and such additional services as physical and occupational therapy, social services, and recreational activities.

Many institutions designated as chronic disease hospitals have evolved, by addition of needed services over the years, from facilities originally intended for nursing and personal care. The resulting variation among facilities, in terms of the availability and nature of services, and differences in terminology give rise to problems in classification. However, data collected by the American Hospital Association indicate that, in 1961, there were 321 long-term general and special hospitals in this country providing approximately 71,000 beds. (See table 5, appendix A.) Increasing interest in developing services for long-term patients has resulted in efforts to define the unique functions of the specialized hospital and the nursing home, as well as the appropriate relationships which should be developed between general hospitals and other facilities for long-term care.

Nursing Homes and Homes for the Aged

During the past three decades, long-term facilities, called nursing homes, convalescent homes, homes for the aged, boarding care homes for aged persons, county homes, and the like, have become a significant part of the complex of medical care resources available for the long-term patient. As a result of historical development and common usage, these terms frequently connote type of ownership rather than the nature of the services provided. Some of these facilities provide only room and board with a minimum of supportive services, while others offer comprehensive services, including medical and skilled nursing care, rehabilitation, dental care, and social casework and group-work services. All of these facilities, however, are characterized by the fact that they predominantly serve aged persons and, to a varying extent, meet the social as well as medical needs of the residents or patients. Currently, only a small proportion of these facilities are affiliated with general hospitals.

An inventory of nursing homes and related types of facilities, conducted in 1961 by the Public Health Service,[1] shows a national total of about 23,000 homes with 592,800 beds, of which 9,700 homes with 338,700 beds provide skilled nursing care. (See table 8, appendix A.) Although nearly 9 out of 10 (87 percent) of the homes offering skilled nursing care are owned by proprietary interests, these homes provide only about 7 out of 10 of the beds.

Mental and Tuberculosis Hospitals

Institutions for long-term care of patients with mental illness, mental retardation, or tuberculosis have, for the most part, developed as independent, geographically isolated facilities, primarily under State or local governmental auspices. Changing concepts of diagnosis, treatment, and care of mental patients, particularly of the older person with complicated medical conditions, have stimulated efforts to revaluate the responsibility of State and local government for providing needed facilities and

[1] U.S. Department of Health, Education, and Welfare, Public Health Service, *1961 Inventory of Nursing Homes and Related Facilities*, Division of Hospital and Medical Facilities. (In process.)

as a corollary, present concepts of utiliza-
mental hospitals are being reexamined.
ing emphasis is being placed upon re-
f selected mental patients to the com-
, where needed care may be provided in
appropriate setting such as specialized
; homes, halfway houses, day centers,
ospitals, or in a home environment.
e decline during the past decade in the
of tuberculosis hospital beds in this
may be ascribed principally to the ad-
new chemotherapeutic techniques and
sequent reduction in need for extended
ional care. Resulting low occupancy
ve caused closure of a number of facili-
ith complete or partial conversion of
to care for other types of patients.
uberculosis facilities have been converted
ing homes and, in fewer instances, to
chronic or mental hospitals or county
ries.

Rehabilitation Centers

The number of rehabilitation centers providing facilities and services for the restoration and retraining of the physically and mentally disabled has grown rapidly since World War II. These facilities are being used increasingly for the chronically ill, both for the restoration of function and the prevention and control of disability. Hill-Burton State plans show that some 200 rehabilitation centers provide comprehensive, coordinated services—medical, psychological, social, and vocational—for the long-term or permanently disabled. Of these, about 170 provide services for multiple disabilities while the remainder are organized to treat only a single disability. These centers usually serve a large geographic area, and a majority of those providing extensive rehabilitation programs are located in or adjacent to the larger cities. A significant number of these centers are integral parts of large general hospitals.

Patient Care in the Home

HEALTH services should be an integral
f the areawide planning agency's pro-
Depending on the patient's needs, these
s may range from the single service of
; care under medical supervision to a
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with the total medical, nursing, restora-
id psychological needs of the patient.
tential value of these services is demon-
by the following:

**nt studies of community need show
ost of the chronically ill aged live in
wn homes and receive either no health
s or totally inadequate care.**

**yses of general hospital utilization
hat from 20 to 30 percent of the ex-
-stay patients have been retained be-
of social rather than medical reasons.**

**eys of nursing homes show that many
s do not need the continuous nursing services of the facility and could be adequately cared for in a home setting elsewhere if some type of nursing and related care were available.**

Though care of the sick at home by the physician was the original basis of medical practice, a new dimension has been added in recent years. To utilize current knowledge in the treatment of long-term patients—whether in the home or in the hospital—the physician rarely serves as a self-sufficient entity. Today he frequently needs the help of such paramedical personnel as nurses, physical, occupational and speech therapists, nutritionists, and social workers. Adequate provision of these health-related services in the home requires that essential resources be developed within the community and that physicians become better oriented to working with these specialists in a home setting.

Coordinated Home Care Programs

In some communities, plans to provide comprehensive care to patients in the home are evolving. These programs, directed at coordination of home care services, are characterized by central administration and coordination of planning, evaluation, and followup procedures to provide physician-directed medical, nursing, social, and related services to selected patients at home. Despite awareness of the need for such programs, their development has been relatively slow. In 1960, only 30 cities had 45 coordinated home care programs. For the most part, these are administered by hospitals. Public health departments and visiting nurse associations are the focal points of administration for a few.

Nursing Care of the Sick at Home

The availability of nursing services for patients in their homes, regardless of age, cause of disability, or financial ability, depends to a great extent on the readiness of community agencies to offer this type of service. A 1961 Public Health Service study [2] showed that 70 percent of all cities with a 1960 population of 25,000 and over (470 out of 676 cities) had at least one agency that provides "nursing care of the sick at home as one of its publicized objectives and offers service to all types of patients and on a continuing basis as needed." Most of these programs (80 percent) were provided by visiting nurse associations. Sponsors of the remainder were either official health agencies or a combination of agencies.

While available statistics do not indicate the extent to which these programs meet existing needs, the extent of coverage is limited by shortage of personnel and inadequate financial support. No data are currently available on the number of home nursing programs in communities of less than 25,000 population.

[2] Bryant, Zella, *Report on Nursing Care of the Sick at Home.* (Item 34 in appendix C, Selected Bibliography.)

Homemaker Services and Foster Home Placement

There is general agreement that expansion of programs of homemaker services, home aid, and foster home placement would help to prevent or postpone institutionalization of many patients, or enable them to return to a home setting from hospitals, nursing homes or other institutions. Eligibility in most programs providing these services is limited primarily to low income families with children, and to aged, chronically ill, or disabled persons.

Despite widespread interest in the use of homemaker services for the chronically ill, there is a serious shortage of such services. According to a 1961 survey,[3] more than 200 agencies were providing homemaker services in 40 States, the District of Columbia, and Puerto Rico. These agencies employed nearly 2,700 homemakers and cared for approximately 5,500 families during 1 month of 1961.

Foster home placement is being utilized by some institutions and community help and social agencies for those chronically ill persons who no longer require care in an institutional setting but do not have a suitable home. Most effective use of this type of arrangement requires close coordination of the services of the foster home placement agency, the hospitals, the physicians, and the employment, educational, and rehabilitation agencies. The number of programs currently in operation is not known, but there is general agreement that it is grossly inadequate to meet existing needs.

Supportive Services

The homebound chronically ill patient may require one or more of a broad range of supportive services. Some examples are social services, nutritional guidance or food service, physical therapy, occupational therapy, speech therapy, dental care, equipment and appliance loan service, pharmaceutical service, laboratory

[3] *Directory of Homemaker Services,* p. 1. (Item 38 in appendix C, Selected Bibliography.)

and X-ray service, and vocational education.

In many communities, well-organized programs of social services provide major benefits to the chronically ill individual and his family. Social workers may provide guidance and aid in connection with financial problems, securing medical supplies and appliances, work adjustment difficulties, and living arrangements. In addition, they offer direct personal service and participate in evaluating personal relationships and physical and social environment in order to assist the patient and his family in adjusting to the implications of illness or disability.

Because of the importance of dietary treatment in chronic conditions, many patients are under medical direction to continue on special diets after discharge from medical care facilities. Dietary consultation in the home is being increasingly utilized to provide vitally needed guidance to the patient and/or family members. Also, programs known as "Meals on Wheels" are being developed to provide hot meals regularly to the chronically ill and aged who are unable to leave their homes or to prepare adequate meals for themselves. Currently there are 26 known nonprofit Meals-on-Wheels programs, with the greatest concentration in the New York and Chicago areas. They serve a total of about 750 homebound persons per day, averaging about 25 to 30 persons per program.

Inadequacies in Current Patterns of Service

Existing patterns or facilities and services in most communities show serious imbalances in both availability and quality of care. Because of the absence of an adequate financial basis for operation, community hospitals and other voluntary agencies have, for the most part, been discouraged from developing needed facilities and programs for long-term patients. Those organizations and individuals who have assumed responsibility for service in this health care area have been forced to fit the services they could offer to the availability of financing.

Many institutions are organized to provide only limited programs of service. Admission of residents or patients is restricted to specific categories. The unavailability within the facility of resources capable of dealing with a variety of patient needs results either in the transfer of a patient with changed needs to another facility, or in the retention of the patient in a facility no longer appropriate to his needs.

Little attempt has been made to develop desirable functional relationships among the various facilities and agencies involved in programing, providing, and paying for services. This, in turn, has hindered the development of effective programs designed to make appropriate services available in accordance with the patient's changing needs.

Because of the lack of adequate controls over programing and construction, certain types of facilities have been overbuilt, with resulting unnecessary duplication of services and uneconomic use of community resources. These developments, coupled with related problems of unsuitable location, lack of access to needed professional competencies and skills, and consequent gaps in service, have inhibited the development of a balanced, comprehensive program of services for the area.

In many States, low licensure standards and lax enforcement procedures have permitted the establishment or continued operation of institutions which do not meet the structural and staffing requirements for high quality service. Utilization by welfare agencies of such substandard facilities, and in some instances of unlicensed facilities, is both detrimental to the physical welfare of the patient and wasteful of the community's economic resources.

Quality of care in long-term facilities suffers from lack of adequately trained personnel. In many instances, inadequate patterns of financing preclude the employment of qualified

personnel even where they are available. Contributing to this problem is the inefficient utilization of available personnel, either because of inadequate medical and administrative supervision, or because of uneconomic duplication of services by several facilities.

Emerging Patterns of Service

Changing Concept of the General Hospital

The general hospital has, in recent years, become increasingly recognized as the center for diagnosis, treatment, and rehabilitation of the chronically ill as well as of the acutely ill. The concept of the truly general hospital today comprises the full complex of health care services, and includes the availability of specialized personnel and of the varied types of services necessary to meet the needs of both inpatients and outpatients.[4] Care and treatment of the long-term patient are assuming increasing importance in this complex of services.

New arrangements for care and imaginative experiments in prevention, treatment, and rehabilitation are now found in some general hospitals and contribute to their expanding role in health affairs. The emerging trend is for experiments which link the hospital with other functioning organizations in the community such as health centers, nursing homes, and homes for the aged and for the development of close cooperation with official and voluntary health services.

Changing Concept of Homes for the Aged

The traditional role of the home for the aged as a shelter primarily for the elderly has changed markedly in recent years. Changes in our culture and economy, particularly since the advent of social security, have caused a significant decrease in institutionalization of the well elderly solely for reasons of shelter, and a shift toward admission of those needing a protective environment because of approaching or advanced infirmity.

The higher incidence of chronic illness among the elderly and the advances in restorative medicine have combined to bring about far-reaching changes in the original function of these institutions. Faced with the alternative of discharging growing numbers of residents who become chronically ill or disabled to hospitals or nursing homes, many homes for the aged have added medical, nursing, and supportive services. Many of those sponsored by religious and other organizations have added beds for nursing care by converting their existing structures or by new construction. Some homes are providing programs of day care for persons who return to their own homes or foster homes at night. For the most part, new homes for the aged are being designed, in terms of structure and equipment, to provide the multiple services needed to meet the physical, social, and medical needs of their chronically ill residents.

Affiliations between Facilities

Demonstrations of the effectiveness of formal operational agreements between hospitals and nursing homes suggest that the development of affiliations between the various facilities and programs serving the chronically ill assists in promoting adequate and uninterrupted patient care. These formalized relationships further assure optimum utilization of scarce specialized personnel, facilitate patient transfers when necessary, help to eliminate duplication of expensive facilities and equipment, and encourage continuous overall medical supervision of patient care.

Day Centers and Night Hospitals

While still in the experimental stage, day centers and night hospitals have been developed

[4] See *Background Statement on Role of Hospitals in Long-Term Care.* (Item 19 in appendix C, Selected Bibliography.)

in a few communities to provide an intermediate stage between inpatient hospital care and relatively independent community living. Patients are in these facilities for a varying number of hours during the day or night and then return to their homes or places of employment. These programs may be operated as part of a general hospital, a community mental health center, a home for the aged, or in conjunction with other community facilities. Although primarily for mental patients, some serve a broader group of the chronically ill. Services provided include diagnosis, medical treatment, physical and occupational therapy, recreation, and other types of care. The program may be extremely flexible in the types of services offered and may serve to maintain some patients in the community as an alternative to full-time institutionalization.

Community-Based Mental Health Facilities and Services

Many patients in mental hospitals can be cared for adequately in community facilities providing appropriate services in a protective environment. As a result of efforts in many localities to avoid unnessary institutionalization, the number of admissions to State mental institutions is decreasing while the use of psychiatric units in general hospitals and of other community facilities for long-term care is increasing. These developments result from better techniques of diagnosis and treatment, recognition of the need to reverse the trend toward excessively large mental institutions, and the desirability of placing the patient closer to his family and friends. In some instances, specialized programs are being developed on a joint basis to assure definitive planning of care and followup of patients.

The community facilities most frequently involved with the psychiatric hospital in these developing programs are chronic disease hospitals, homes for the aged which offer extensive medical care, and nursing care institutions which provide continuous medical supervision and trained personnel. The success of these programs depends upon placement practices which consider both the best interests of the patient and of other patients in the facility.

Restorative Services

The growing numbers of chronically ill and disabled persons, the rising cost of medical and institutional care, and the demonstrated benefits of restorative treatment have combined to bring about recognition of the value of programs of rehabilitative service for the long-term patient. Evidence of the effective results obtained for these patients in comprehensive rehabilitation centers has encouraged hospitals and other medical care facilities to place increased emphasis on the provision of programs of restorative therapy, designed to achieve or maintain the highest attainable level of function.

Preventive Services

Closely related to the concept of restoration and preservation of maximum function is the growing recognition of the need for prevention of physical, emotional, and social dependency and disability. Prevention is an integral part of the total care program and should involve the family physician. A number of community agencies and institutions have inaugurated various kinds of preventive programs and services. These services, limited primarily by the availability of professional resources, include different forms of case-finding programs, specialized clinics, adult education programs in health maintenance and nutrition, and counseling services in senior centers and social agencies.

Dental Services

Dental services in the home have been made possible in recent years through the development of portable dental equipment which enables the dentist to provide service at the patient's bedside—whether the setting is in the hospital, the nursing home, or the patient's own

home. Thus, the range of dental services available to the homebound patient can be greatly extended.

Central Referral Services

Specialized programs offering information and referral services to long-term patients have been developed in a number of communities, frequently as a part of or in cooperation with local community health and welfare councils. Occasionally, these services are provided in local health departments. Programs range in complexity from the development of a simple roster of resources to a well-organized activity providing (1) person-to-person counseling to help patients and their families find the appropriate service to meet their needs; (2) information about health, welfare, and recreational facilities and services; and (3) referral to employment, housing, and long-term medical facilities. Significantly, these activities may represent a first step toward coordinated community planning.

Changing Roles of Official and Voluntary Agencies

The traditional roles of official and voluntary health agencies appear to be changing. Evidence of a merging of interests and responsibilities is found in the increasing participation by official agencies in the service programs of voluntary agencies, and in the increasing assumption by voluntary agencies of responsibility for enforcing standards of care. To a greater extent, official health agencies are joining with hospitals and the health professions in attacking problems of health care in the community. Examples of these emerging relationships include programs of school health services, the provision of care and services for crippled children, and the provision of nursing care in the home.

This trend toward increasing cooperation and coordination of effort has particular implications for the planning and development of programs of adequate care for long-term patients.

Chapter IV
Planning Principles

EFFECTIVE AREAWIDE planning [1] for the needs of the long-term ill and disabled cannot be done in isolation. Plans for development and coordination of appropriate resources must relate to other planning efforts and to other health and welfare activities in the area. Programs of prevention and control of disease and accidents have an important bearing upon need for long-term care services. Similarly, such factors as availability of adequate income, suitable housing, personal counseling, sheltered employment, and homemaker services directly affect the programing of services needed by the chronically ill.

Heretofore, planning in these areas by community health and welfare councils or by official health agencies has too frequently been directed to resolving particular problems, rather than to the total complex of community needs and resources. Planning for the development of an orderly system of facilities for long-term care should include consideration of total patient needs for service. It should, therefore, be closely correlated with other health and welfare planning, and it should be directed toward evaluation and programing of total community needs.

Areawide planning for facilities and services provides a process through which all factors relating to the care of long-term patients can be brought together and considered as an interrelated whole. The process enlists the services and skills both of community leaders and of persons experienced in the disciplines involved in long-term care. It necessitates definition of the nature and scope of the problem and identification of those aspects of the problem that remain to be resolved. It provides to the public a description of areawide needs and stimulates the action necessary to achieve a comprehensive pattern of care.

BENEFITS OF AREAWIDE PLANNING

THE PRIMARY BENEFITS of the areawide approach to planning stem from its emphasis on involvement in the planning process of all agencies and individuals concerned with providing care and service to the long-term patient. Through joint study and analysis of the needs and resources of the area, a better mutual understanding can be developed of the operational strengths and weaknesses of various facilities and services, and of their adequacy in terms of the total needs of the community. Specific benefits of areawide planning may include the following:

Opportunities will be provided for involving physicians in an expanded role in the treatment of the long-term patient.

[1] As used in this document, the term "areawide planning" describes the continuing process through which hospitals and related health facilities coordinate their planning within a designated geographical area. The process is facilitated through an areawide health facility planning agency which has responsibility for: (1) preparation of profiles of area resources and needs; (2) cooperative activities with public and private financing and planning agencies; (3) consultation in each phase of health facility planning; and (4) evaluation of planning proposals in the light of established criteria.

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Hospitals and nursing homes will benefit by the increased assurance of an adequate financial basis for programs of long-term care, and welfare departments will be able to demonstrate that the funds for which they are responsible will be expended both constructively and prudently.

Health personnel can be utilized at greater potential.

Official and voluntary agencies, responsible for establishing and maintaining standards essential to the provision of high quality services and care, will obtain greater community understanding and support.

Community leaders, through their involvement, will be better equipped to elicit and direct support for community facilities and services.

The detailed study of areawide needs and resources, implicit in the planning process, will assist in stimulating needed action in the field of legislation and financial support.

The Planning Area

To the extent possible, the geographic area for which the planning group assumes responsibility should reflect a community of social, economic, and political interest. The area should be of sufficient size to permit development of a pattern of comprehensive services, yet not so extensive as to lessen the potential effectiveness of community leadership and the advantages of community participation. Consideration should be given to patterns of geographic coverage already established by other planning or service organizations in the area, with a view to combining and coordinating their activities within a proposed areawide pattern of service.

Before final determination of the planning area boundaries, the cooperation of the State Hill-Burton agency should be sought and joint consideration should be given to the service areas already established in that agency's plan for construction of hospitals and related health facilities.

Responsibility for Planning

Responsibility for planning for long-term facilities should be vested in an areawide health facility planning agency. Principles to be followed in the formation and organization of such an agency are outlined in a report developed by a joint committee of the American Hospital Association and the Public Health Service entitled "Areawide Planning for Hospitals and Related Health Facilities."[2]

The areawide planning agency should: (1) have a governing body composed of members drawn from the top echelon of lay and professional community leadership; (2) be responsible for a specifically designated geographic area; and (3) have close working relationships with hospitals and related health organizations within the area, the health professions, the community leadership, and groups and agencies that control and influence sources of financing. Close collaboration should exist between the State Hill-Burton agency and the local planning agency.

Where a well-organized areawide planning agency has already been established, it should be encouraged to assign a high priority to the planning of long-term care facilities and services. Where no areawide planning agency exists, or where the agency lacks sufficiently

[2] U.S. Department of Health, Education, and Welfare, Public Health Service. *Areawide Planning for Hospitals and Related Health Facilities.* (Item 16 in appendix C, "Selected Bibliography.")

broad membership to deal with the problem adequately, action should be taken by community leadership, or by the State or local government, to stimulate the formation of a new council or the reorganization of the existing body, with extension of its responsibility to include planning for long-term facilities.

Adequate staff and funds must be made available for the planning activities related to long-term care to provide needed special competencies and to finance necessary study activities. In addition to a staff director, competent statistical, technical, and clerical skills should be provided. To assure continuity of the planning and programing process, and of related procedures for implementation, a long-range pattern of financing should be developed, utilizing such media as fund raising campaigns, foundation grants, membership dues, allocation of public funds, and other available resources. Funds should be sufficient to permit detailed evaluation of area needs, analysis of all available data, development of realistic and attainable short- and long-range objectives, and the establishment of continuing procedures to implement these objectives and to permit regular revaluation of the objectives and operating programs.

Basic Principles for Planning and Programing

As a planning prerequisite, the areawide planning agency should formulate clearly defined basic objectives, sufficiently broad to encompass the needs of the community, yet consonant with the cultural and economic patterns of the area. Factors to be considered include the types of services and facilities best suited to meet the particular needs within the community based on the best knowledge available, the feasibility of providing these services and facilities within the limitations of existing and anticipated community resources, and the degree to which community acceptance and support can be expected.

Once these basic determinations have been made, the development of a definitive plan to achieve the specified objectives should take into account the following planning principles:

1. Planning should include the entire complex of facilities and services for the long-term patient.

Comprehensive planning for long-term care facilities requires that consideration be given to the entire range of facilities and services needed for optimum treatment and care. As a prerequisite, information must be developed on the availability, adequacy, and anticipated roles of all existing facilities and services, including such resources as diagnostic and treatment clinics, offices of physicians and dentists, and home care and social service programs. Gaps in service may then be identified and consideration given to stimulating the construction, or to the realignment or addition of facilities and services, needed to achieve a comprehensive program of care.

As a part of the planning process, individual institutions should identify the present and anticipated functions they will perform within an interrelated pattern of services. Principles of good care and effective use of personnel and economic resources dictate that all institutions, in their individual planning, be cognizant of the various services available in or being planned by other institutions or programs serving the community.

2. Planning of facilities both for short-term acute and for long-term treatment and care should be undertaken by the same areawide planning agency.

Unified planning for all types of facilities for patient care will result in better patient management, more effective utilization of available resources, and more realistic planning and programing of needed additional facilities and services. By encompassing the full gamut of

patient needs, unified areawide planning can result in wiser guidance to patient care facilities for their individual planning, and can stimulate the development of demonstration projects necessary to achieve improved patient care.

3. The general hospital and its organized staff should accept responsibility for the provision of facilities for long-term treatment and care, either through the construction or allocation of facilities or through relationships with one or more established facilities.

The need for a planned program for providing convalescent and long-term care, either within the framework of the general hospital or closely related to it, has become apparent. Related to this is the recognized need for assuring long-term treatment and care of acceptable quality, whether it is provided in the general hospital as a component service or in a separate facility to which the hospital's medical staff can transfer patients and with which the hospital can develop the reciprocal relationships essential to continuity of care. In the interest of optimum use of the area's facilities, it is often advisable for a general hospital to develop relationships with other general hospitals that have established long-term care facilities, or with already existing long-term care institutions, rather than constructing additional facilities.

4. Planning for long-term care facilities should be based on detailed knowledge of the population group to be served and its needs for various types of services.

Basic data for planning should be as comprehensive as possible. In addition to a determination of the number of individuals receiving treatment for chronic illness or impairment, current waiting lists should be studied to develop an indication of present demand for various types of facility care. Efforts should also be made to survey current patient loads of practicing physicians, and of nursing and related service organizations, in order to identify non-institutionalized patients who could benefit from institutional care. To the extent possible, patient data should be classified by functional ability, potential for recovery, and need for protective, personal, and social services. Detailed analysis and interpretation of these data are necessary to determine the types of facilities and services best suited to meet the specific needs of the population group.

5. Existing community resources should be utilized at maximum efficiency.

Facilities and programs already serving long-term patients in the community should be carefully evaluated in terms of effectiveness of program, adequacy of staff, and suitability of structure and location. Properly constructed, well-operated facilities that provide needed services should be urged to extend or improve their programs so as to function most efficiently as part of a coordinated areawide pattern of services. Facilities found to be unsuitable or in excess of apparent community needs should be recommended for elimination, rebuilding, or conversion to other more appropriate uses.

Professional skills are invaluable community health resources. Duplication of services and fragmentation of responsibility result in wasteful use of these scarce skills. The areawide planning agency should, therefore, promote optimum use of professional skills through coordination of services.

6. Facilities and services for long-term care should be coordinated through formal agreements.

Individual patients, over a period of time, may require care and treatment from several sources. As an essential element in assuring continuity of medical service, existing facilities and service organizations, including general hospitals, should be encouraged to define the specific roles they can and will perform within a well-balanced program of services for the long-term ill. Once these roles have been mu-

tually accepted, the various activities which they encompass should be coordinated into a communitywide pattern of service, and formalized by cooperative agreements. These agreements should include definite allocations of the functions to be performed by the cooperating facilities, including arrangements for reciprocal services, joint use of specialized staff such as physical therapists and dietary consultants, exchange of patient information, and easy transfer of patients as necessary.

Development of close working relationships between general hospitals and other long-term care facilities, preferably through contractual affiliation, should be encouraged. Assurance thus provided that the specialized services of the hospital will be readily available to physicians supervising patients in related programs of long-term care should result in decreased demand for admission and reduced length of hospital stay. This, in turn, will permit more effective utilization of general hospital beds.[3]

7. Facilities should be organized to provide continuity of patient care.

To the extent possible, facilities should be developed and organized to provide the range of services which the long-term patient may require during the course of his illness.

As a patient's treatment progresses, his service needs will vary. The planning process should recognize that a substantial number of long-term patients will be transferred from a facility providing intensive treatment to facilities more appropriate to their changed needs. These transfers are desirable both for economy and for optimum use of scarce health competencies. Similarly, the probability of recurrent need of long-term patients for acute treatment makes necessary the ready availability of the intensive services of the general hospital.

The planning process should stimulate the development of specific arrangements between related facilities: (1) to assure that appropriate services will be available at such time and to the extent necessary to meet the patient's current needs; (2) to assure the continuing availability of essential clinical and social information; and (3) to promote continuity of care. Special emphasis should be given to the development of procedures for easy transfer, as necessary, to intensive treatment facilities.

8. Patient placement should be in accordance with need for service.

Facilities and programs will be used most effectively if long-term patients are placed according to their primary needs for service and if patients with similar service needs are placed together, either in a single extensive facility or in separate specialized facilities. The consequent increase in operational efficiency should result in better patient care, more effective use of available staff, and optimum utilization of existing facilities.

Determination of a patient's needs for service should be made by a practicing physician, with the assistance of nursing, social work, and other personnel as required. Subsequent placement should be based on thorough knowledge of the patient's medical and social circumstances, and on a realistic evaluation of the services available in existing facilities and through programs of out-of-institution care.

9. Physical transfer of long-term patients should be minimized.

Permanent transfer of long-term patients between institutions, or transfers for extended periods of time, should occur only when necessitated by pronounced changes in the patient's need for service. If the patient load warrants, various types of services should be provided within the same facility in order to minimize

[3] Basic recommendations on need for coordinated programs and services were developed by a Workshop on Hospital-Nursing Home Relationships under joint sponsorship of the American Hospital Association, American Medical Association, American Nursing Home Association, Blue Cross Commission, and U.S. Public Health Service. Published in *Proceedings of Workshop on Hospital-Nursing Home Relationships.* (Item 21 in appendix C, Selected Bibliography.)

physical transfers and the inevitable emotional disturbance to the patient. Older people, in particular, should not be required to change their surroundings unnecessarily.

10. Facilities for long-term care should be so located that the services of an organized medical staff are readily accessible.

Because of their varied and frequent need for medical treatment and supervision, long-term patients should have ready access to a wide range of medical and related services. Whenever feasible, facilities for long-term care should be established in close proximity to an organized program of medical and therapeutic services, found most frequently within the setting of a general hospital or other medical complex. Physical proximity would facilitate the development of cooperative relationships and help to assure both the availability of medical and related competencies and accessibility to specialized facilities and techniques as needed.

In addition, location near an existing complex of services within a community would provide easier access by patients to religious and recreational facilities in the community, and would make possible more frequent visits by relatives and friends.

11. The concept of preventive and restorative care should be incorporated in all long-term treatment programs.

A prime objective of every facility for the chronically ill and disabled should be to prevent disability and to assist the patient to retain or recover maximum use of his remaining capabilities. In order to minimize the extent of disability and to prevent secondary disability, an evaluation of the patient's rehabilitation potential should be made, under medical supervision, as early in his illness as possible. If at all feasible, a program of restorative services, including periodic revaluation, should be instituted and continued until maximum gain has been realized. Thereafter, programs of sustaining services should be provided to maintain the patient at his optimum functional level.

12. Home care services should be an integral part of areawide planning for facilities and services.

Many chronically ill and aged persons now receiving care on an inpatient basis do not require the specialized resources of a hospital or the formal supervision of a nursing or custodial home. Under a properly organized home care program, the service needs of these patients may be adequately met in their own homes. Similarly, for some patients, care at home may precede, follow, or be interspersed with care in a hospital or other institution.[4]

Well-organized home care services will help to prevent situations requiring hospitalization; moreover, by assuring continuity of medical and nursing services, these programs would facilitate early discharge from the hospital. Adequate periodic assessment of patients on home care is essential.

13. Programs for supervision and maintenance of health of persons residing in homes or housing for the aged are essential elements of areawide planning for long-term care.

The expansion of housing for the aged under community or religious sponsorship or through urban housing development requires the parallel development of organized supervisory and maintenance health services. The areawide planning agency should encourage such homes or housing authorities to establish appropriate programs of health care, including preventive services, or to enter into agreements for provision of adequate supervisory and maintenance health services with health departments, hospitals, and other community health services.

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[4] Commission on Chronic Illness. *Chronic Illness in the United States.* Vol. 2, "Care of the Long-Term Patient", p. 31. (Item 1 in appendix C, Selected Bibliography.)

14. Community programs for early detection, treatment, and rehabilitation of persons with mental illness should be an integral part of areawide planning programs.

Current treatment techniques give added emphasis to the feasibility and desirability of community-based treatment facilities for the mentally ill. The areawide planning agency should encourage one or more general hospitals within the planning area to establish or expand facilities for diagnosis and short-term treatment of persons in early stages of mental illness. Consideration should also be given to the development of formalized programs to which patients discharged from State psychiatric facilities may be referred for after-care and rehabilitation. These programs may include day and night hospitals for persons who are in the process of being assimilated into the community, as well as specialized nursing homes and organized outpatient clinics.

Areawide planning for community-based psychiatric care should include consideration of the special needs of the emotionally disturbed.[5]

15. The need for tuberculosis facilities and programs should be considered as part of planning for long-term care.

Recent advances in the medical treatment of tuberculosis have made it possible to treat tuberculous patients in community-based facilities, and special units in general hospitals. The need for organized treatment services at the community level, and the necessity of extended medical supervision and treatment of other medical and surgical conditions of tuberculous patients, should be considered by the areawide planning agency in developing an adequate total program of care.

Where sufficient need exists, specialized tuberculosis facilities or units should be programed, but they should be in close relationship to general hospitals. Existing tuberculosis facilities that are not fully utilized should be considered for conversion to use in other programs of long-term care, if they meet accepted standards of structural and functional suitability.

16. The areawide planning agency should encourage the adoption and use of standards for construction, maintenance, and operation, as advocated by recognized national authorities.

In the interest of better patient care, the adoption and enforcement of adequate standards for licensure and for eligibility for grants-in-aid or loan programs should be actively supported by the areawide planning agency. All long-term care facilities and services in the area should be required to comply with these standards and encouraged to exceed them. In addition to their use as bases for upgrading the quality of patient services, these standards should serve as criteria against which proposed new construction or programing in the area could be evaluated. Pressures for long-term beds should not be permitted to result in the toleration by the regulatory agency of substandard facilities and services.

17. Higher quality of care should be promoted through the development of programs of education and training.

Improvement of patient care can be promoted by the planning agency through stimulation and support of organized educational and training programs for professional and paramedical staff of long-term institutions. In many instances, education and training may be provided through a formalized program conducted by a qualified educational institution. In addition, up-to-date concepts and procedures essential to good care may be brought to the staffs of long-term institutions through organized inservice training programs involving regular visits by qualified professional personnel.

[5] The problem of the emotionally disturbed is discussed in the report of the Surgeon General's Ad Hoc Committee on Planning for Mental Health Facilities, *Planning of Facilities for Mental Health Services.* (Item 14 of appendix C, Selected Bibliography.)

18. Planning for long-term care facilities and services should be based on patient needs rather than on the availability of funds.

The planning, organization, and development of facilities and services for long-term care should not be influenced by sources of funds or restrictions which may be attached to available methods of financing construction or operation. In the interest of optimum patient care and economic use of available resources, proposals for unnecessary or inappropriate types of facilities or services should be actively opposed.[6] If restrictions applied by financing agencies, either public or private, have an adverse influence on planning for facilities or services, the planning agency should undertake action to modify or remove these restrictions, or it should develop new financing methods. Patient needs for service should be the prime determinant in the planning, organization, and development of facilities for long-term treatment and care.

19. Programs of research and evaluation should be established as a guide for continuing development of the planning process.

To assess the effectiveness of planning and implementation, the areawide planning agency should promote the development of continuing programs of research and evaluation of selected factors affecting the provision of long-term services within the planning area. Examples of pertinent areas of study include: numbers and types of patients served, patterns of treatment, patient placement, patterns of referral, length of stay, effectiveness of staff utilization, methods of payment and use of funds, and the effectiveness of interservice relationships. The reliability of research results as bases for future planing action will depend upon the extent and quality of cooperation provided by the participating institutions, organizations, and agencies.

20. A greater proportion of funds raised through community fund-raising campaigns should be allocated to long-term care facilities and services.

In general, programs of long-term treatment and care receive less than their proportionate share of the funds provided for health facilities through fund-raising campaigns. The increasing demand for long-term services and the resulting need for capital and operational funds make it essential that financial assistance for these programs be sought from all available sources. Demonstration of the relative need for long-term care facilities and services, in comparision to other programs of health care, should provide a basis for requesting increased allocations from public fund-raising drives.

[6] This problem is discussed in *Areawide Planning for Hospitals and Related Health Facilities.* (Item 16 in appendix C, Selected Bibliography.)

Chapter V

Overcoming Obstacles

REALISTIC PLANNING for long-term care will depend upon the quality of leadership exercised and the accurate identification of the various factors that may affect the proposed program. Relevant legislation and regulations, current economic trends, and social attitudes toward long-term illness should be assessed to determine their influence upon planning recommendations and their projected development. In particular, factors that might impede the realization of the planned program must be identified and analyzed so that appropriate measures can be initiated to minimize or offset their influence.

The general areas requiring attention include: existing and proposed methods of financing construction and operation; availability of qualified staff; adequacy of organizational, administrative, and regulatory procedures; and the possible influence of prevailing social and cultural attitudes within the area.

FINANCIAL CONSIDERATIONS

THE ESTABLISHMENT and operation of an adequate system of facilities and services for the long-term patient is not inexpensive. Costs of treatment and care of the chronically ill and disabled vary widely, depending upon the nature and severity of the illness or disability and on the type of care being provided. Differences between the costs of caring for the acutely ill and for the long-term patient have been found frequently to reflect differences in quality of the services furnished. Per patient expenditure for long-term care may well exceed the comparable cost for the short-term patient, particularly if high quality care is provided. Efforts to expand or improve the services provided by facilities for long-term patients will be directly influenced by the extent to which new or improved patterns of financing can be developed, both for initial costs of needed construction and for continuing costs of operation.

Availability of Capital Financing

In programing additional construction, the planning group must consider the possible sources of capital funds and the capability and willingness of prospective sponsors to provide the type and quality of service for which present and potential need has been determined.

Potential sources of funds for capital construction include tax revenues, funds received through contributions or bequests, and private investment. Identification of the source from which funds may be anticipated for specific construction projects will depend primarily upon the nature and sponsorship of the planned construction and on its proposed utilization. Certain types of facilities, for example, have traditionally been constructed and supported by public funds; proposed construction or expansion of these facilities must accordingly involve consideration of the availability of such funds. Similarly, the availability of funds for remodeling or expanding existing facilities will be influenced by the nature of the present sponsorship and the avenues of financial support which have already been established.

A number of States have developed programs of direct grant assistance to qualified sponsors for construction of needed long-term

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facilities. The possibility of involving other levels of government in these programs as means of stimulating needed construction should not be overlooked. State, county, and local governments, through their programs of public assistance and aid to the aged and disabled, are already heavily involved in financing the care and treatment of the long-term patient.

The Hill-Burton program has, since its inception in 1946, made grant funds available through State agencies for the construction of general, chronic disease, mental, and tuberculosis hospitals. Since 1954, similar funds have been provided for constructing facilities offering skilled nursing care. Integration of local planning into the statewide plan will ensure that Hill-Burton funds will be allocated to projects programed and approved by the local planning group.

Additional sources of capital financing include fundraising campaigns, charitable organizations, foundations, programs of organized philanthropy, and individual bequests. Heretofore, funds provided for health facility construction have been utilized principally by general hospitals. The increasing importance of long-term illness makes it essential that a larger proportion of the funds from these sources be allocated to facilities for the treatment and care of long-term patients.

Finally, funds available for private investment, if directed into facilities providing high quality of care, can materially assist in achieving areawide goals for long-term care. Federal assistance for constructing privately owned nursing homes is available through the Federal Housing Administration in the form of mortgage insurance and through the Small Business Administration as a direct or participating loan. The Federal Housing Administration also administers a mortgage insurance program for rental or cooperative housing and related facilities for the elderly. Related facilities may include infirmaries or other inpatient or outpatient health facilities.[1]

[1] See Major Federal Aid Programs for Community Hospitals. (Item 4 in appendix C, Selected Bibliography.)

Cost of Maintenance and Operation

Although capital construction funds are important, adequate financial support for maintaining and operating facilities for long-term care is of equal or greater importance. No other single factor has as great an influence on the quality of institutional patient care.

Revenue for the maintaining and operating of long-term care facilities has heretofore been obtained primarily from direct patient payments and through allocation of tax funds. In recent years some Blue Cross plans have gained experience in covering services beyond those in general hospitals. Some plans are covering benefit days other than for inpatient care in lieu of a lesser number of unused hospital days, thereby encouraging appropriate use of facilities and programs. A growing number of plans are also offering benefits to those over age 65 in skilled nursing facilities, as well as in programs of visiting nurse services. Some commercial insurance companies provide insurance benefits beyond hospital care under major medical programs.

Despite progress in recent years, rates of payment by State and local welfare and public assistance programs in most instances do not cover the cost of adequate care for the indigent or medically indigent chronically ill patients who are their responsibility. In addition, failure to provide for long-term supportive services as well as short-term care has adversely affected the efficient utilization of existing facilities, and has deterred development of needed additional facilities. The planning agency, in cooperation with other groups, should urge State and local governments to appropriate sufficient funds to enable public agencies purchasing care and those operating long-term facilities, to make available the quality of care required.[2] As a supplemental approach, the planning group should explore the feasibility of State, county, or local subsidies to exist-

[2] Commission on Chronic Illness, *Chronic Illness in the United States*, Volume II, "Care of the Long-Term Patient," p. 432. (Item 1 in appendix C, Selected Bibliography.)

ing acceptable institutions as an incentive to expand their facilities and services.

Recent and proposed changes in Federal legislation which would provide assistance in financing medical care of the aged should be carefully considered by the local planning group. Evaluation of the potential impact of these measures on the effective demand for services and on the need for long-term care facilities and programs within the area may influence planning objectives and the procedures proposed for their implementation.

Personnel and Staff Shortages

The scarcity of qualified personnel acts as a deterrent to the development of needed facilities and services. Although personnel shortages exist in virtually every field of health endeavor, they are particularly pronounced in the field of long-term care. The areawide planning agency should, therefore, be actively concerned with programs of recruitment, training, standards, utilization, and personnel policies within its area.

The role of the planning agency in personnel programs within its area will depend greatly on the local situation. In all cases, the agency should participate fully with other organizations and agencies, encouraging, stimulating, coordinating, or lending needed assistance. Where no programs exist, the agency should initiate them, in cooperation with other interested groups. In many instances, the agency may serve as a factfinding body. Some of the problems that arise in this area, and some approaches to their solution, are discussed in the following paragraphs.

Heretofore, professional specialization in treating and caring for the chronically ill and disabled has been considered less challenging and less rewarding than work with the acutely ill. Relatively larger proportions of qualified personnel have accordingly been attracted to other areas of health service. This lack of professional interest, compounded by use of available health competencies at less than peak effectiveness, presents a major obstacle to attempts to develop a comprehensive program of long-term services.

Improvement in personnel policies and working conditions will strengthen the competitive position of long-term care facilities, and provide a firmer basis for an active recruitment program. Additional measures to alleviate shortages include: review and reassignment of functions within a facility to make more effective use of trained personnel; joint utilization of specialized personnel by two or more facilities or agencies; and the development of in-service training programs. The possibility of more extensive use of qualified part-time or semiretired personnel, volunteers, technicians, and aides to supplement the services of professional personnel, should not be overlooked. Moreover, the development of facility-based programs for training the family to care for the patient at home would assist in conserving skilled manpower. Selection of the particular measures to be used in a given local situation will depend upon the types of staff skills needed, the availability of qualified personnel within the planning area, and the probability of a productive response to recruitment efforts.

In addition to the shortage of skilled personnel, the related problem of standards for the various staff competencies should be reviewed. In the interest of improving patient care, those standards that are not commensurate with the desired quality of care should be recommended for revision, and proposals should be made for reassignment of present staff to functions more appropriate to their skills.

Finally, efforts should be made to increase the pool of available health manpower through programs of professional education and in-service training, and to induce a greater proportion of trained personnel to enter the field of long-term care. Current programs of medical, nursing, and social work education should be reoriented to place increased emphasis on the

characteristics and treatment of the long-term patient and on his needs for service. Training programs for licensed practical nurses and nurses aides should be expanded and recruitment activities intensified.

More emphasis should be given to training personnel already engaged in providing service to long-term patients. A growing number of official and voluntary health agencies are offering financial assistance for training programs for nursing home personnel. Similarly, hospitals and professional associations are giving more recognition to inservice education and training programs. Problems of financing these programs must be recognized and additional financial resources developed for training in needed skills and competencies.

Training programs for paramedical personnel, particularly those in the various therapies and in social work, are not being fully utilized; these programs should be made more attractive through modernization of curricula, active recruitment, and direct financial assistance to personnel attending. In all programs, opportunity should be provided for training and experience in all the settings in which patients receive care, including their own homes.

Organizational, Administrative, and Regulatory Considerations

In most communities, services for the chronically ill and disabled are marked by division of regulatory responsibility and lack of coordination of activity and objectives. These conditions, which result from the historical pattern of development of long-term care, present several problems which must be evaluated and resolved if an effective pattern of services is to be achieved. Consideration of these problems is essential to identify need for changes in patterns of organization, administrative practice, and regulations and standards.

Unsuitable Facilities and Programs

Some institutions and programs originally established in response to a specific community need may now have outlived their period of maximum effectiveness. Because of the nature of their programs, limited objectives, and the quality of the services, or because of the physical condition of structures, these facilities and services may not be suitable for incorporation in the proposed pattern of coordinated services. Depending on the character of the deficiencies, determinations must be made and agreements reached as to the alternatives of modernization of the structures; redirection of program emphasis; possible combination with other programs; conversion to other use; or elimination.

Similarly, agencies whose primary objectives are no longer appropriate, or which are operating inefficiently, should be persuaded to modify their programs, combine with other agencies, or terminate their activities in the interest of more effective utilization of available funds and resources.

Fragmentation of Responsibility

In most communities, responsibility for providing services to long-term patients is divided among a number of agencies and institutions. Programs of medical care, visiting nurse services, nursing and custodial care, social work services, and restorative services are frequently provided by different organizations. Each has its own objectives and responsibility for only a limited aspect of care or treatment, or for a restricted group of eligible persons.

Under this fragmented approach, little consideration is given to the patient's total needs, or to the interrelated nature of these needs. Arrangements for appropriate services or for transfer between services, become more difficult, with resulting higher patient costs, inefficient

use of services, and less than optimum patient care. Problems of patient management become magnified, because of the loss of continuity of physician services and the difficulty of followup by related service personnel. In the interest of more effective treatment and continuity of patient care, the various responsibilities for patient care must be identified and efforts made to coordinate the related activities into a comprehensive pattern of services more closely attuned to the patient's total needs. The areawide planning agency provides the logical mechanism through which this can be accomplished.

Low Licensure Requirements

In a number of States, failure to establish or to enforce adequate standards of construction and care has encouraged the development of nursing care facilities providing a low quality of service. Preemption by these institutions of the existing demand for services has, in some areas, inhibited the development of more adequate facilities. A favorable climate for improvement of care and services should be provided by raising requirements and by developing more effective procedures for their enforcement.

Primary responsibility for establishing and enforcing standards for patient safety and adequacy of basic services in these facilities rests with the State licensing authority, which in most instances is the State health department. This authority should be stimulated to review licensure requirements and the effectiveness of enforcement procedures. Where other agencies of State government are involved in the licensing process, recommended procedures for improvement should be developed on a cooperative basis. In this connection, special consideration should be given to the adequacy of structures that have been converted from other uses. As a minimum, the areawide planning agency should strongly recommend and work toward gradual elimination of all hospital and nursing facilities located in converted dwellings.

In some States, power to impose additional licensing requirements is vested in agencies of county and municipal government. The planning agency should enlist the active support and cooperation of these groups to assure a more effective inspection and enforcement program.

Inadequate Service Standards

In the interest of improved patient service, appropriate standards of performance and of program adequacy are needed. In many facilities and programs, inadequate consideration has been given to such factors as the availability and use of consultative and rehabilitative services, adequacy of staff training and education, maintenance of appropriate patient records, and periodic patient evaluation. Present standards of patient care which may be considered for adoption by the planning agency, in whole or in part, include the registration program of the Joint Commission on Accreditation of Hospitals; the standards of medical and nursing care approved by the American Medical Association, the American Nursing Home Association, and the American Hospital Association; the standards of the American Nurses Association; and those adopted by the National Social Welfare Assembly.[3 4 5]

The standards accepted by the planning group should be recommended for adoption by all participating facilities in the area. While immediate conformance may not be possible, demonstrated progress toward compliance with these standards should be required as a condition for continuing participation by the facility in the areawide planning process.

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[3] *Nursing Care of the Chronically Ill and Aged*, Approved by the Board of Trustees of the American Hospital Association, 1961. (Item 39 in appendix C, Selected Bibliography.)

[4] *Guides for Medical Care in Nursing Homes and Related Facilities*, Approved by the American Medical Association, the American Nursing Home Association and the American Hospital Association, 1960. (Item 40 in appendix C, Selected Bibliography.)

[5] *Standards of Care for Older People in Institutions*, 3 volumes, National Social Welfare Assembly, Inc., New York, 1953. (Item 43 in appendix C, Selected Bibliography.)

Lack of Continuity of Patient Information

The changing needs of the long-term patient may occasionally require his transfer from one facility to another more appropriate to his changed status. At these times, the problems of proper diagnosis and development of suitable plans for care would be materially lessened if information developed in earlier phases of treatment were made available, under appropriate safeguards, to the receiving facility of service.

Ideally, this information should be furnished in advance of actual patient transfer. As a minimum, case summaries should be forwarded when the patient is transferred to another facility or service. The areawide planning agency could stimulate and assist in the development of a standard referral form to expidite the transfer of essential information between facilities.

Zoning Problems

Zoning regulations in some areas may present barriers to proposed construction of needed facilities at locations which would be most advantageous in terms of proximity to anticipated patient sources or to related medical or other long-term facilities. In other instances, absence of adequate zoning restrictions may permit eventual deterioration of an area in which facility construction is being planned. Such factors as zoning laws, trends in land use, and land costs should be carefully considered by the areawide planning agency in terms of their present and future impact on planning objectives.

Social and Cultural Attitudes

Lack of widespread public understanding of the magnitude and urgency of the need for long-term care facilities and services presents a major problem to the development of effective measures to meet this need. There is, moreover, little understanding of the necessary components of good programs of chronic care. Extensive programs of community education are required to stimulate public awareness of the growing problems of long-term care and to develop a sense of community responsibility for assuring adequate, properly staffed facilities and services for long-term patients.

The need for community education is especially evident in the field of care and support of the aged and infirm. The specialized nature of the services required by this group and the lack of appropriately organized programs of service are only beginning to be recognized. The areawide planning agency should evaluate public attitudes toward the problems of chronic illness and disability in order to successfully implement its long-term care program. If it fails to stimulate public interest in and recognition of the needs of long-term patients, its attempts to attract public support will be seriously hampered.

Professional Attitudes

Because of administrative and financing problems, hospital administrators and boards of trustees have, for the most part, shown little interest in establishing needed facilities and services for patients with long-term illness. Organizations and individuals currently involved in providing long-term services are reluctant to accept proposed changes affecting the organization or administration of their programs. Physicians and persons in the other

health professions tend to consider care of long-term patients less interesting and less rewarding than work in other fields of health endeavor, and have been diverted to areas of professional interest considered more attractive.

Positive action by the planning agency to reorient these attitudes of professional groups is essential if a coordinated plan for high quality services is to be achieved. Because of their key positions in the management of patients, physicians and hospital administrators, in particular, must be stimulated to assume major roles in planning and organizing long-term services into a comprehensive pattern of care.

Chapter VI

Developing and Implementing the Areawide Plan

AREAWIDE PLANNING, which affects the interests of many people and groups, is something more than the formalization of a blueprint for specific action. It must be viewed as a continuing dynamic process, responsive to the changing characteristics of the population and adaptable to shifting needs. Successful implementation of an areawide program for long-term care facilities and services will depend upon the quality of leadership exercised by the areawide planning agency and the degree of cooperation generated among the various organizations and agencies toward achieving planning objectives. The value of planning is dependent upon its acceptance, and acceptance, in turn, is affected by the understanding and involvement of lay and professional individuals and groups who can contribute both to the planning and to program implementation.

While the specific problems to be resolved will depend upon the characteristics of the local situation, certain general considerations will be applicable to all areas. In this context, planning consists of the following steps, several of which may occur concurrently:

Recognition of the existence of an areawide problem of such magnitude that its solution requires the cooperative activity of a number of organizations and agencies.

Organization of an areawide planning agency with a governing body drawn from the top echelon of lay and professional community leadership.[1]

Establishment of written agreements with other community planning groups defining collaborative functions and specific spheres of interest and concern.

Fact gathering, research in depth when appropriate, and analysis of data.

Delineation of problems through data interpretation and review, determination of gaps in services, and identification of planning objectives.

Establishment of standards and criteria, based on those recommended by qualified national bodies, for measuring planning proposals.

Stimulation of individual organizatons and agencies to consider the findings and recommendations of the areawide planning agency in their self-evaluation and planning.

Development of demonstrations, when appropriate, along with research to evaluate results.

Establishment of ad hoc groups to study and seek solutions to specific problems delineated by the areawide planning agency.

Review of planning proposals developed by individual organizations and agencies or by ad hoc groups to determine whether they meet standards and criteria established by the areawide planning agency.

Phasing of planning proposals, when required, on a short- and long-term basis.

Followup, on appropriate occasions, to assure community understanding and support in implementing planning proposals.

Ongoing evaluation of progress in achieving planning objectives.

Revaluation of planning determinations in terms of new developments or new information.

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[1] See recommendations in *Areawide Planning for Hospitals and Related Health Facilities*, p. 15. (Item 16 in appendix C, Selected Bibliography.)

Organization for Planning

The organization for planning must be suitable to the planning function to be performed. It must have the authority and capability to achieve its objectives. Planning for long-term facilities should proceed hand in hand with planning for short-term acute illness facilities as part of the total areawide planning activity. Because such problems do not exist to the same degree in all communities and areas throughout the country, they must be examined and resolved by local initiative through the development of short- and long-range planning objectives geared to the needs of the area.

A major factor in assuring the development of coordinated planning objectives which will be supported by the community is adherence to sound principles in organizing and designating membership on the governing board of an areawide planning agency. Basic principles relating to the organization and function of such an agency are set forth in the joint report of the American Hospital Association and the Public Health Service, "Areawide Planning for Hospitals and Related Health Facilities." Foremost is the principle that the areawide planning agency should have a governing body comprising members drawn from the top echelon of lay and professional community leadership. The agency should be organized on a permanent basis, with sufficient staff and operating funds so that it can adequately discharge its responsibility to the community.

Since other planning groups in the fields of patient care, health, welfare, and physical planning may already exist in the area, it is important to correlate the functions of an areawide planning agency for patient care facilities with the functions of these other groups and to recognize their spheres of interest and concern. Such correlation may take time, but upon its success will rest the future acceptance by people and groups already involved in serving the long-term patient. Through this correlation of effort, the areawide planning agency may gain access to pertinent information and to the services of staff members of these groups whose special skills will be invaluable to the planning process. Since the planning determinations will be sufficiently complex and widespread to create possible program and jurisdictional misunderstandings, the relationships that are worked out should be set forth in written agreements for formal adoption by governing boards of each collaborating agency. The understanding and endorsement of these planning determinations by professional organizations and societies concerned with the problem will help to achieve community acceptance.

Close cooperation should also be developed with State and local government agencies responsible for health, welfare and licensing. In particular, collaboration should be developed with the State Hill-Burton agency, which is charged by statute with the preparation of an annual State Plan for both long- and short-term patient care facilities. The areawide planning agency should be formally recognized by the State Hill-Burton agency.

Data Required for Planning

Collection, tabulation, and analysis of data are essential to the planning process. Availability of adequate and valid data provides a sound basis for delineating problems, identifying gaps in service, and determining planning objectives. Before undertaking the task of data collection, an areawide planning agency should consider the formation of a joint technical committee composed of representatives of collaborating planning agencies. The individuals selected should be qualified in procedures for data collection, tabulation, and analysis, and in facilitating access to required sources of information.

As the first step in collecting basic data, current studies and surveys of long-term patient

care facilities and services should be examined. Next, using the data thus collected, supplemented as necessary by agency surveys, a series of profiles should be developed as part of a qualitative inventory of present facilities and programs in the area and of estimates of current and potential demand for care. These may be listed as follows:

Profile of existing facilities and services:
Numbers, type, size, sponsorship, structural and functional condition, admission policies, and relationships with other facilities and services.

Profile of current patients:
Numbers, type, length of stay, rate of flow into and out of facilities, method and amount of payment.

Profile of available medical and related personnel, including professional groups:
Data covering physicians, dentists, professional and practical nurses, aides, special therapists, social workers.

Profile of population:
Trends, age groups, concentration, socioeconomic and cultural characteristics, and prevalence of chronic illnesses.

Profile of topography:
Transportation routes and costs, natural barriers, shopping centers, and location of facilities and services.

Profile of socioeconomic conditions:
Income, housing, aging centers, and educational and activity opportunities.

From the above profiles, estimates of requirements may be developed, including:

Current requirements—met and unmet:
These would be based on such factors as population characteristics, morbidity rates, type and amount of financial support, and the characteristics of inpatient population, both in hospitals and in nursing homes.

Potential requirements:
These would be based on the effect of changes in population, in morbidity rates, and in financing methods as well as on new systems of relationship between services.

In some instances preliminary review and analysis of basic data will reveal problem areas requiring more intensive examination and study. In such situations a research program, carried out in depth, may be appropriate. Here again, technical committees of qualified people can greatly assist in developing research protocol and in suggesting procedures for developing community understanding and support.

To assure that the goals established for the planning process are being achieved, procedures adopted for data collection and analysis should be revaluated at regular intervals. Arrangements should be made for regular review of procedures with collaborating groups and cooperating government agencies so that the data-gathering programs may be correlated with those carried out by these agencies.

Developing Conclusions and Recommendations

The validity of planning conclusions will depend upon the degree of judgment that can be brought to the interpretation of data and to the review of the complex pattern of needs and obstacles involved in the planning process. Particularly in the delineation of problems that exist in the planning area will the staff of the areawide planning agency benefit from the guidance of members of the agency's governing body. This body may also wish to request collaborating planning groups to appoint representatives to a joint planning policy committee which can participate in interpreting data and in reviewing problem situations.

The adoption of professional and physical standards is essential to the accurate delineation of existing problems as well as to the review of planning proposals developed by individual organizations and agencies. In addition, principles of sound financing require the develop-

ment of criteria for efficient operation of programs and prudent use of resources. These criteria may relate to size, location, and staffing of a service facility or an operating agency. Standards and criteria published by qualified national bodies, such as the American Hospital Association, American Medical Association, Federal Housing Authority, Joint Commission on the Accreditation of Hospitals, American Nurses Association, National League for Nursing, and the Public Health Service, will serve to guide an areawide planning agency in establishing realistic standards and criteria for its planning area.

Data obtained for each long-term patient care facility should be sufficiently detailed to permit a reliable evaluation of the effectiveness of its services; appropriateness of location in relation to the population being served and to other patient care facilities; appropriateness of sponsorship; admission qualifications; payments for service; and structural potential for expansion, addition of new services, or conversion to other uses. Only those facilities found to be currently or potentially acceptable for service should be considered for inclusion in determining future planning objectives.

Certain vested interests in the area will be directly affected by the conclusions and recommendations that are developed and by the standards and criteria that are established. In general these interests are professionally oriented and can be expected to support planning determinations. However, their acceptance can be more readily obtained if professional committees are set up to review planning determinations and advise on matters of policy. The assistance of membership associations of physicians, nurses, and other professional groups, and of hospitals, nursing homes, and homes for the aged should be sought in setting up such committees.

Involvement of Organizations and Agencies

The validity of planning determinations and the degree to which program objectives can be attained will be influenced by the extent to which the areawide planning agency can achieve close cooperative relationships with other organizations and agencies active in promoting health, patient care, and State and local planning.

Local community hospitals should be urged to accept a major role in the pattern of services to be developed for long-term patients. Agreements with these institutions should be worked out early in the planning process in regard to their acceptance of responsibility for key activities, and for effecting necessary changes in physical organization, current patterns of operation, and existing functional relationships with other facilities and programs in the area.

Out-of-institutional programs also play an important role in providing needed services to the long-term patient. Pertinent data on these programs should be developed and an evaluation made of the adequacy of existing programs, quality of service, and potential for future use.

In counseling with individual facilities and programs in the area, staff of the areawide planning agency can interpret general planning determinations and the findings arising from evaluations of specific facilities and programs. Each organization and agency should be encouraged to form its own planning group to study information developed by the areawide planning agency, to define its specific community role, and to initiate the development of realistic programs and plans. Staff can assist this group by suggesting questions that should be considered and by reporting on other facilities and services in the area which may supplement services or duplicate facilities.

When major planning problems are identified that cannot be solved through the efforts of one organization or agency, the areawide planning agency may suggest that an ad hoc group be established to study the problem in depth and to develop alternate solutions. Membership on such a committee should be

drawn from organizations and agencies that have an interest in the problem and from people who have demonstrated their ability to contribute to the delineation and solution of community problems.

Physician participation in the program is essential to assure proper medical management of the patient, the adoption of appropriate professional standards, and the coordination of services required to meet patient needs. Decisions as to patient placement, provision of specialty services, and scheduling of possible transfer should involve the physician, in cooperation with hospital administrators, hospital and visiting nurses, and social workers, as indicated.

Chronic illness centers, which provide information, referral and counseling services, should be encouraged to participate in the planning process. Such centers serve as a focal point for assisting any chronically ill person, regardless of his referral source, by providing information, consultation, and referral to an appropriate facility whether for needed diagnostic procedures or for care and treatment.

Local planning and coordinating organizations in the health and welfare field have an important role in planning long-term care facilities. Whenever possible, they should be involved through formal cooperative relationships, such as representation on the board and participation in ad hoc committees. Agreement on respective functions should be reached. Channels of communication should be developed so that reports and findings on such matters of mutual interest as identification of needed services may readily be brought before the areawide planning agency. Such cooperative relationships should be sought with community welfare councils, health councils, and hospital councils.

Local health departments, through their legal and administrative responsibility for community health problems, can exert a direct and authoritative influence on the nature and quality of community services. Their knowledge of local needs and of existing community resources should place them in a favorable position for stimulating activity in the field of long-term care, developing appropriate motivations, and acting as catalysts for necessary action. Their direct concern with health maintenance programs and with problems of prevention and control accentuates the need for early involvement of these agencies in the planning process and for securing their continuing support in implementing the program.

Similarly, local welfare departments have long been instrumental in providing and financing various medical care services for the needy and indigent. As purchasers and providers of care and service for welfare recipients, these organizations have a direct influence on the demand for long-term care and on the quality of services being provided. Close cooperative relationships must be developed with these agencies if coordinated planning is to be effective.

Responsibility for developing a statewide plan for hospital and medical facilities, including those for long-term care, is vested in the State Hill-Burton agency. By establishing close collaborative relationships with that agency, the areawide planning agency can be assured of consultation, guidance, and direct assistance in formulating areawide planning objectives, and of subsequent endorsement and support of recommended projects. Recognition of the local planning group's cooperative affiliation with the Hill-Burton agency will help to promote local acceptance of its planning decisions and recommendations for construction.

Coordination of State and local planning efforts would assure that areawide planning will be in accord with the planning guidelines and techniques endorsed by the Hill-Burton State agency. Incorporation of local decisions into the statewide plan and program for construction would be more easily realized. Moreover, there would be greater assurance that grant funds available under the Hill-Burton program would be allocated to desirable projects within the area. Endorsement of proposed construction projects by the areawide planning agency should be a prerequisite to allocation of Hill-Burton funds.

Other State organizations involved in the prevention, care, and treatment of long-term illness include State mental health agencies, in-

stitutional authorities, programs for tuberculosis prevention and control, and departments of vocational rehabilitation. Development of cooperative relationship between these programs and the areawide planning agency would provide mutual benefits through interchange of information, proper allocation of responsibility, improved utilization of available services, and better programing of needed facilities and services.

Review and Phasing of Planning Proposals

The efficacy of an areawide planning agency will be evidenced by the skill with which it balances proposals for construction or development of services against the needs of the planning area and the availability of financing, and by the extent to which it achieves desirable modifications of existing facilities and services. Procedures for handling planning proposals submitted by individual organizations and agencies, or by ad hoc groups, should be developed early in the planning process. These should include the method for submitting proposals, procedures for consultation, rules for both private and public hearings, and provision for public announcement of support or disapproval. Throughout the process, primary emphasis should be placed upon the needs of the area as a whole, rather than on any one segment of the population or on the interests of a particular group.

In some areas, the number of desirable planning proposals may exceed the availability of financing. Under such circumstances the areawide planning agency will find it necessary to develop, jointly with all interested parties, an acceptable pattern for phasing planned facilities and services. Some proposals will be given short-term priority while others will receive a long-term priority. In determining priorities, the areawide planning agency should consider both the need for a particular facility or service and the ability of individual organizations and agencies to secure necessary financing.

Of importance to phasing proposed construction is the development of a detailed body of knowledge of existing and potential resources for capital financing. Availability of this information will help to stimulate needed construction, to encourage responsible sponsorship, and to develop an orderly schedule for construction of needed facilities. Possible sources of construction financing which should be investigated include: Federal, State, and local tax funds; philanthropy, both private and institutional; private investment capital; public bond issues; accumulated capital revenues; fund-raising activities; and private borrowing. In addition, other potential sources of capital funding should be explored, including those less commonly used in the field of long-term facility construction, such as labor unions and charitable organizations.

The areawide planning agency should assume responsibility for active assistance to sponsors of approved construction, through formal endorsement of requests for capital funds and by support of specific projects in fund drives. Similarly, planning proposals not in conformance with estabished planning objectives should be actively discouraged through dissuasion and by refusal of endorsement for financial assistance.

Continuing Review and Revaluation

As part of its planning responsibility, the areawide planning agency should undertake continuing programs of review and evaluation of the various factors affecting the availability

and quality of patient services. The information thus developed will provide needed bases for necessary action.

In many areas, attempts to improve patient service in long-term patient care facilities have been hampered by low State licensing requirements. To assure adequate quality of construction and patient care, an areawide planning agency should encourage and support programs designed to review minimum standards of construction and operation and to stimulate upward revision. Conformance to these standards should be required as a prerequisite to acceptance of an existing or proposed facility in the planned pattern of long-term care.

Studies of payment practices and of adequacy of operating income of facilities and programs within the area should be initiated and encouraged. Possible expansion of prepayment benefits to such services as skilled nursing care, rehabilitative services, and home care should be explored. Inadequate payment for long-term patient care services by State and local welfare agencies have frequently resulted in difficulty in patient placement and in provision of low quality patient care. The areawide planning agency, in cooperation with State and local organizations and voluntary groups, should stimulate the development of an active program of publicity, education, and direct appeal to appropriate authorities to develop more adequate State and local financing of services based on a system of full cost reimbursement.

Public understanding and approval of the activities of the areawide planning agency will be reflected in the degree to which planning objectives and recommendations are accepted by organizations, agencies, and individuals providing long-term patient care. For this reason, procedures should be developed for adequate publicity throughout the area through published reports, organized presentations, news releases, and radio and television programs. Special groups such as service organizations, chambers of commerce, union groups, and influential individuals should be kept informed through regular distribution of appropriate publicity and progress reports.

The planning process can never be static. New developments and new information will necessitate periodic revaluation of planning determinations. Revaluation procedures should be built into the planning process to allow the governing body of the areawide planning agency and all collaborating planning bodies to effect necessary modifications in accordance with changing conditions. As new situations develop, the areawide planning agency should stimulate the establishment of more appropriate patterns of patient care and, where feasible, the realignment of existing facilities to meet the changed needs.

A number of developments are occurring with which the areawide planning agency will wish to keep abreast. Stimulated by corporate and large individual givers, several cities have embarked upon united campaigns to raise money to construct short- and long-term patient care facilities. Since there is considerable competition for funds raised by this method, an established and accepted procedure for review and hearings can be of great importance to community acceptance of united fund objectives.

An areawide planning agency can serve in other ways to assist the planning process. It can employ technically qualified personnel, such as architects and engineers, to review plans and specifications and to oversee the letting of contracts. If consultants in specific specialties are retained, they can also give advice and guidance to sponsors of prospective and existing facilities and programs. The agency can explore the need for coordination of programs of education and training and can give leadership and guidance to the initiation and implementation of planning in this field. It can investigate the need for research into problems related to the care of the long-term patient and to the administration of long-term patient care services, and can stimulate and direct the steps required to set the research in motion and to secure adequate financing and staffing.

Appendix A

BACKGROUND REFERENCE DATA

Problems of Long-Term Illness and Care

Prepared by

Program Evaluation and Reports Branch
Division of Hospital and Medical Facilities
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Fact Sheet 1

Prevalence of Long-Term Illness

Dimensions of the Problem

● According to the U.S. National Health Survey, an estimated 74 million persons, or 42 percent of the civilian noninstitutional population of the United States, were reported as having one or more chronic conditions during the two-year period ending June 1961.

● Of these, a total of over 19 million persons, or 11 percent of the population, had a chronic condition that prevented or limited their usual activity.

For 14.2 million persons, this limitation was so severe as to result in an inability or reduced ability to work, to keep house, or go to school.

Each person reported to have a chronic activity limitation had an average of 1.4 chronic conditions.

Affects All Ages

● While chronic illness affects persons of all ages, a disproportionate number of elderly persons are affected to some extent by a chronic disability.

Over 12 million individuals, or nearly four-fifths of all persons aged 65 or older who were not in institutions at the time of the survey (1959–61), had some kind of chronic condition—nearly twice the proportion of individuals in the general population.

Severity of Chronic Conditions

● As age increases, the impact of chronic illness becomes more severe. Thirty-eight percent of persons 65 years of age and over were limited in major activity, in contrast to 4.8 percent of those aged 17–44.

● During 1959–60 some 2.8 billion days of restricted activity resulting from illness or injury were experienced—an average of 16 days per person in the civilian noninstitutional population of the United States.

● Older persons report more disability days than do younger persons.

Persons under 45 years of age averaged 12 days per year, compared with about 38 days per person aged 65 and over.

● Bed-disability days totaled 1.1 billion, or more than one-third (37 percent) of the total days of restricted activity.

Persons aged 65 and over averaged 14 days per person, in contrast to about 4 to 8 days per person in the younger age groups.

Duration of Chronic Limitations

● Nearly 6 million persons, or 42 percent of the 14.2 million with chronic limitations affecting their major activity, had their present degree of limitation for 5 years or more.

● More than 5 million were so limited from 1 to 4 years and 2.1 million had such chronic activity limitations for less than a year.

Conditions Most Frequently Reported

● During 1959–61, the chronic conditions most frequently reported as causes of activity limitation were heart disease, arthritis and rheumatism, mental and nervous disorders, high blood pressure, impairments of lower extremities and hips, visual impairment, and paralysis (complete or partial).

Fact Sheet 2

Characteristics of Long-Term Patient Care

General Hospital Care

● The average length of stay in general stort-stay hospitals increases substantially with the age of the patient.

According to the U.S. National Health Survey, during 1958–60 the average hospital stay for the civilian noninstitutional population was 8.4 days in these hospitals; children under 15 years of age averaged 6.0 days, and persons aged 65 and over had an average of 14.9 days.

○ More than one-fourth of the total hospital days for patients discharged from general short-stay hospitals was for a hospital stay exceeding one month.

For patients 65 and over, nearly two-fifths of the days were for stays of 31 days or longer.

Mental Hospital Care

● The proportion of older persons in mental hospitals has been increasing markedly.

In 1958 on any given day about one out of every three beds in public mental hospitals in the United States was occupied by a person aged 65 or older.

Since 1939, the ratio of persons aged 65 and over hospitalized for mental illness to the total aged population has increased 40 percent, while for all other age groups there has been a steady decrease in the ratio.

In 1958, first admission rates to public mental hospitals showed a substantial increase with advancing age, particularly among those aged 65 and over. More than one-fourth (27 percent) of all first admissions were aged 65 and over.

These aged mentally ill who are currently in mental hospitals are about equally divided among the following two groups: (1) those admitted at younger ages and who have grown old in these institutions (schizophrenic patients constitute the greatest proportion), and (2) those admitted at aged 65 and over, 83 percent of whom are diagnosed as having senile and arteriosclerotic brain damage.

Nursing Home Care

● According to the 1953–54 Public Health Service and Commission on Chronic Illness 13-State survey, and similar recent State and local surveys, patients in proprietary nursing homes are aged, severely disabled, chronically ill, and stay for prolonged periods.

Average age is 80 years—with one-fourth over 85 and only one-third under 75 years of age.

Two-thirds are women.

At the time of the survey, less than one-half could walk alone; one-fifth were confined to bed; more than one-half were mentally confused at least part of the time; one-third were incontinent; and two-thirds had some heart or circulatory condition.

Average length of stay, at time of 1953–54 survey, was one year.

● Nearly one-half of the patients in proprietary homes required nursing care which would not ordinarily be given in a patient's home.

Physicians' Visits

● Not only do the aged spend more time in general hospitals, but they also have a higher rate of physician visits.

During 1957–59, those aged 65 and over averaged 6.8 visits per year, in contrast to adults aged 25–64, who averaged about five visits annually.

Personal Care at Home

● During 1958–59, according to the U.S. National Health Survey, approximately 1.1 million persons in the civilian noninstitutional population reported they required constant or part-time personal care in their home for such activities as dressing and eating. Members of the household provided the bulk of such care.

Approximately 650,000 persons, or 60 percent of the reported individuals, required constant care.

Paralysis, circulatory conditions, senility, and arthritis and rheumatism accounted for more than one-half of those receiving care.

Of the estimated 3.5 million persons in the civilian noninstitutional population having a major activity limitation, only about one-fourth (862,000) were reported as receiving some personal care at home.

● Prevalence rate is higher among the older age groups—rising from about 2 persons per 1,000 population in the younger ages (under 44) to 88 per 1,000 at age 75 and over.

Of those aged 65 and over, nearly one-fourth (23 percent) reported they had been receiving such care for 5 years or more.

Fact Sheet 3

Medical Care Expenditures

- Persons aged 65 and over spend nearly twice as much per capita for medical care as the general population.

  About 28 percent of their total medical bill is for hospital care; 31 percent for physicians' services; and 23 percent for drugs and medications.

- In 1959, less than one-half of the noninstitutional population aged 65 and older was covered by some form of hospitalization insurance, 37 percent by surgical insurance, and 10 percent by insurance for doctors' visits outside the hospital. For the total population, the rates of coverage were considerably higher—67 percent, 62 percent, and 19 percent, respectively.

- The U.S. Department of Labor Consumer Price Index shows that medical care costs have risen more than any other expenditure category.

  Using 1957–59 prices as a base, 1961 medical care prices have increased 11.3 percent, compared with a 4.2-percent increase during the same period for all commodities, including medical care items.

Cost and Charges of Nursing Home Care

- Costs and charges for nursing home care vary widely. In the 13 States covered by the 1953–54 survey conducted by the Public Health Service and the Commission on Chronic Illness, the median monthly charge for care was $154—such charges ranging from about $90 to $200 in the various States. The range in individual homes was, of course, much greater. Although not directly comparable, more recent studies show that monthly costs range from a low of $100 to a high of more than $400. Factors influencing costs are staffing, size of facility, comprehensiveness of care provided, and economic status of area.

- During 1953–54, one-half of the patients in proprietary nursing homes were recipients of public assistance, with such funds paying the full bill for four out of five of these patients.

- Public assistance payments generally lag considerably behind charges for similar care to private patients.

Fact Sheet 4

Community Health Services and Facilities Act of 1961

● Although broad in its provisions, the Community Health Services and Facilities Act of 1961 is designed to stimulate improvements in out-of-hospital services, especially for the chronically ill and aged (Public Law 87-395, October 5, 1961), offering additional Federal aid to:

State health departments for establishing and expanding out-of-hospital community health services for the chronically ill and aged.

Public and other nonprofit agencies for experiments, studies, and demonstrations of new methods of providing out-of-hospital services.

Public and other nonprofit organizations for the construction of nursing homes.

● The 1961 legislation provided for the following:

Increased the authorization for matching grants for the construction of health research facilities from $30 million to $50 million a year.

Authorized the Congress to earmark appropriations for formula grants for specific purposes. Through this provision, increased funds are being made available for community health services.

Vested project grant authority in the Public Health Service and authorized the appropriation of $10 million a year for project grants to be awarded to private nonprofit and public organizations for the development of new and improved community health services outside of hospitals.

Authorized more money for hospital research and demonstration ($10 million annually compared to the previous $1.2 million ceiling) and liberalized the terms so that, for the first time, these funds can be used to make grants for portions of facilities that involve experimental design features or equipment.

Increased the Hill-Burton grant authorization for nursing home construction from $10 million to $20 million.

Liberalized the provisions for granting Hill-Burton assistance for the construction of rehabilitation facilities. Formerly, rehabilitation funds were available only for centers that offered medical, psychological, social, and vocational services. Under the new law, any nonprofit rehabilitation

center that will offer medical plus one of the three other services is eligible for construction funds.

Major program areas with which the studies, demonstrations and experiments deal include nursing homes, home nursing, coordinated home care, homemaker services, disease detection centers, community organization, and dental health.

Fact Sheet 5

Hill-Burton Hospital and Medical Facilities Construction Program

Legislative Background

1946

Hospital Survey and Construction Act—Hill-Burton Program—enacted in August 1946 (Public Law 79–725, Title VI of the Public Health Service Act)—authorized funds for grants to States for:

Surveying needs and developing State Plans for construction of facilities.

Assisting in constructing and equipping needed public and voluntary nonprofit general, mental, tuberculosis and chronic disease hospitals, and public health centers.

1949

Amendments authorized the Public Health Service to conduct and make grants for research, experiments, and demonstrations relating to the effective utilization of hospital services, facilities, and resources (Public Law 81–380, October 1949).

1954

Amendments broadened program to provide specific grants for construction of public and voluntary nonprofit nursing homes, diagnostic and treatment centers, rehabilitation facilities, and chronic disease hospitals (Public Law 83–482, July 1954).

In the 1954 appropriation bill, funds were appropriated to the Public Health Service for the first time to conduct and make grants for hospital research (although authorization for such research was provided in 1949 amendments).

1958

Amendment gave sponsors who meet the standard eligibility and priority qualifications the option to take a long-term loan in lieu of a grant (Public Law 85–589, August 1958).

1961

Community Health Services and Facilities Act of 1961 (Public Law 87–395, October 1961).

Increased appropriation authorization for construction of nursing homes from $10 to $20 million annually.

Raised annual research appropriation authorization to $10 million and authorized experimental and demonstration construction and equipment projects.

Appropriations

● Hill-Burton appropriations have varied from $75 million for 1948 fiscal year to $220 million for 1963 fiscal year.

1963 fiscal year appropriations

$20 million for chronic disease hospitals

$20 million for nursing homes

$10 million for rehabilitation facilities

$20 million for diagnostic or treatment centers

$150 million for hospitals and public health centers

Long-Term Care Projects Approved

● By December 31, 1962, a total of 234 chronic disease hospital and 439 nursing home projects providing a total of 42,639 long-term care beds had been approved for Hill-Burton assistance involving

$457.8 million in total project costs

$143.0 million in Hill-Burton funds

$314.8 million in State and local funds

Fact Sheet 6

Small Business Administration Construction Program

Provisions of Program

- Inaugurated in August 1956 (Public Law 85-356).
- Provides commercial loans to hospitals, convalescent and nursing homes, and medical and dental laboratories for:

  Construction of new facilities, expansion or improvement of existing facilities.

  Purchase of equipment, facilities, machinery, supplies or materials.

  Working capital.

- Facilities must be privately owned and operated for profit and must qualify as a small business:

  A hospital qualifies if its capacity does not exceed 100 beds.

  A convalescent and nursing home qualifies if its annual dollar volume of receipts does not exceed $1 million.

- Direct loans by SBA alone—statute maximum, $350,000.
- Maximum maturity period of an SBA loan is 10 years.
- Maximum interest rate is 5½ percent except in designated area redevelopment areas where the interest rate may not exceed 4 percent.

Nursing Homes Assisted

- As of December 31, 1962, a total of 337 loans amounting to $23.4 million had been approved for nursing homes.

Fact Sheet 7

Federal Housing Administration Program

Provisions of Program

- Housing Act of 1959 (Public Law 86–372) authorized the Commissioner of the Federal Housing Administration to insure mortgages for the construction or rehabilitation of qualified proprietary nursing homes.

  Projects must be skilled nursing homes of not less than 20 beds.

- FHA must receive certification from the agency responsible for administering Hill-Burton program of State where nursing home is located that:

  Home is needed.

  Reasonable minimum standards for licensing and operating are in force in State.

  Satisfactory assurance that such standards will be applied and enforced with respect to nursing homes insured under this program.

- Maximum interest rate is 5¼ percent plus FHA insurance of one-half of 1 percent.

- Maximum mortgage maturity period is 20 years.

- Mortgage may involve up to 90 percent of the estimated value of the completed project.

Nursing Homes Assisted

- As of December 31, 1962, FHA approved mortgage insurance for 166 projects totaling $80 million.

Fact Sheet 8

State Licensure Programs for Nursing Homes and Homes for Aged

● When the health department is the official licensure agency, a variety of administrative patterns exist; in the majority, both licensure and the Hill-Burton construction programs are under the same director.

In other State health departments, licensure program functions are related more closely to chronic disease and aging programs.

● Regardless of its administrative location within the licensure agency, there is usually a separate unit responsible for licensing nursing homes and homes for the aged. This unit works with other programs in the State health department such as public health nursing, public health nutrition, environmental health and safety, and chronic disease to bring their services to nursing homes for the aged.

Nursing Homes

● All States and Territories, excluding Guam and the Virgin Island, license nursing homes. The licensure responsibility is assigned to several types of agencies.

In 46 States and Territories, the licensing agency is the State health department. In three States it is the State welfare department and in two States and the District of Columbia, agencies other than health and welfare have such responsibility.

Homes for the Aged

● Only Alabama, Guam, Puerto Rico, South Carolina, and the Virgin Islands do not license these facilities.

In 39 States, the health department is the agency having the licensure responsibility. In seven States, it is the State welfare department and in two States and the District of Columbia, agencies other than health and welfare have such responsibility.

Table 1. **POPULATION: Total Population,[1] by Age, United States, 1900–1980**

Year (as of July 1)	Population (in millions)					Percent of total population			
	All ages	Under 19	20 to 44	45 to 64	65 and over	Under 19	20 to 44	45 to 64	65 and over
1900	76.1	33.7	28.8	10.5	3.1	44.2	37.9	13.8	4.1
1910	92.4	38.7	36.2	13.6	4.0	41.8	39.1	14.7	4.3
1920	106.5	43.3	41.0	17.1	4.9	40.7	38.5	16.1	4.6
1930	123.1	47.6	47.2	21.6	6.7	38.6	38.4	17.5	5.4
1940	132.1	45.3	51.6	26.2	9.0	34.3	39.0	19.9	6.8
1950	151.7	51.4	57.1	30.8	12.3	34.0	37.7	20.3	8.1
1960[2 3]	180.0	69.1	58.2	36.1	16.6	38.4	32.4	20.0	9.2
1962	186.6	73.0	59.0	37.3	17.3	39.1	31.6	20.0	9.3
Projections:									
1970:[4]									
II	214.2	86.6	65.3	42.3	20.0	40.4	30.5	19.7	9.4
III	208.9	81.4	65.3	42.3	20.0	38.9	31.2	20.2	9.6
1980:[4]									
II	259.6	108.8	82.1	44.2	24.5	41.9	31.6	17.0	9.4
III	245.7	94.9	82.1	44.2	24.5	38.7	33.4	18.0	10.0

[1] Includes armed forces overseas.
[2] Census of April 1, 1960.
[3] Includes Alaska and Hawaii.
[4] The Series II and III projections are based on differing assumptions of fertility.

Source: U.S. Department of Health, Education, and Welfare, Office of the Secretary. Health, Education, and Welfare Trends: 1962 Edition. Washington, D.C., U.S. Government Printing Office, p. 3 and Health, Education, and Welfare Indicators, December 1962, p. 1.

Table 2. **PREVALENCE OF CHRONIC ILLNESS: Persons with Limitation of Activity Due to Chronic Conditions, by Age, United States, July 1959–June 1961**

Age	Total population	PERSONS WITH ONE OR MORE CHRONIC CONDITIONS					
		Total	No activity limitation	Having some activity limitation			
				Total	Not in major activity [1]	In amount or kind of major activity [1]	Unable to carry on major activity [1]
	Number of persons (000's)						
All ages....	176,302	73,849	54,577	19,273	5,056	10,243	3,974
Under 17.....	61,911	11,116	9,996	1,120	580	407	133
17 to 44.....	63,068	28,596	23,943	4,652	1,630	2,600	422
45 to 64.....	35,989	22,068	15,475	6,593	1,803	3,745	1,045
65 and over.....	15,334	12,070	5,162	6,908	1,043	3,491	2,374
	Percent distribution of persons						
All ages....	100.0	41.9	31.0	10.9	2.9	5.8	2.3
Under 17.....	100.0	18.0	16.1	1.8	.9	.7	.2
17 to 44.....	100.0	45.3	38.0	7.4	2.6	4.1	.7
45 to 64.....	100.0	61.3	43.0	18.3	5.0	10.4	2.9
65 and over.....	100.0	78.7	33.7	45.1	6.8	22.8	15.5

[1] Major activity refers to ability to work, keep house, or go to school.

Source: U.S. Department of Health, Education, and Welfare, Public Health Service, National Health Survey, Chronic Conditions Causing Limitation of Activities, United States, July 1959–1961. Health Statistics Series B—No. 36, Washington, D.C., U.S. Government Printing Office, October 1962, p. 19.

Table 3. **PREVALENCE OF CHRONIC ILLNESS: Distribution of Persons with Chronic Activity Limitation Affecting Major Activity,[1] by Duration of Limitation and by Age, United States, July 1959–June 1960**

Age	Total persons with major activity limitation [1]	DURATION OF MAJOR ACTIVITY LIMITATION [1]			
		Under 1 year	1 to 4 years	5 years or more	Unknown
	Number of persons (000's)				
All ages	13,573	2,115	5,039	5,680	739
Under 17	539	130	213	175	(*)
17 to 44	2,887	622	924	1,193	147
45 to 64	4,598	779	1,703	1,936	180
65 and over	5,549	583	2,199	2,376	391
	Percent distribution of persons				
All ages	100.0	15.6	37.1	41.8	5.4
Under 17	100.0	24.1	39.5	32.5	(*)
17 to 44	100.0	21.5	32.0	41.3	5.1
45 to 64	100.0	16.9	37.0	42.1	3.9
65 and over	100.0	10.5	39.6	42.8	7.0

[1] Major activity refers to ability to work, keep house, or go to school.
(*) Magnitude of the sampling error precludes showing separate estimates.

Source: U.S. Department of Health, Education, and Welfare, Public Health Service, National Health Survey. Duration of Limitation of Activity Due to Chronic Conditions, United States, July 1959–June 1960. Health Statistics Series B—No. 31, Washington, D.C., U.S. Government Printing Office, January 1962. p. 12.

Table 4. **DISABILITY DAYS: Number of Restricted-Activity and Bed-Disability Days per Person per Year, by Age and Sex, United States, July 1959–June 1960**

Age	Restricted-activity days [1]			Bed-disability days [2]		
	Both sexes	Male	Female	Both sexes	Male	Female
All ages	16.2	14.3	18.0	6.0	5.3	6.7
Under 5	10.8	11.0	10.6	4.7	4.9	4.6
5 to 14	11.6	11.4	11.9	5.0	4.7	5.2
15 to 24	9.8	7.7	11.6	4.1	2.9	5.1
25 to 44	13.9	10.6	17.0	4.8	3.8	5.8
45 to 64	21.6	19.1	23.9	7.4	6.7	8.2
65 and over	37.8	36.8	38.6	13.6	13.1	13.9

[1] A day on which the person reduced his usual activities because of illness or injury.
[2] A day on which a person was kept in bed all or most of the day because of illness or injury.

Source: U.S. Department of Health, Education, and Welfare, Office of the Secretary. Health, Education, and Welfare Trends: 1961 Edition. Washington, D.C., U.S. Government Printing Office, 1961, p. 20.

Table 5. **HOSPITAL FACILITIES AND UTILIZATION: Distribution, by Type of Hospital, United States, 1961**

Type of hospital	Number of—			Average daily census (000's)	Occupancy (percent)	Average length of stay (days)
	Hospitals	Beds (000's)	Admissions (000's)			
All hospitals	6,923	1,670	25,474	1,393	83.4	.....
Non-Federal:						
Short-term general and other special	5,460	659	23,375	489	74.3	7.6
Voluntary	3,305	458	16,974	349	76.1	7.5
Proprietary	848	38	1,566	25	65.4	5.8
State and local governmental	1,307	162	4,835	116	71.5	8.8
Psychiatric	483	715	376	654	91.6	.....
Tuberculosis	222	49	65	36	73.6	.....
Long-term general and other special	321	71	155	60	84.8	.....
All Federal	437	178	1,503	153	86.4	.....

Source: American Hospital Association. Hospitals: Part II, Guide Issue, 36:414–415, August 1, 1962.

Table 6. **UTILIZATION OF SHORT-STAY HOSPITALS:[1] Patients Discharged, Hospital Days, and Average Length of Stay, by Age, United States, 1958–1960**

Age	Average annual number of discharges			Average annual number of hospital days			Average length of stay (days)
	Number (000's)	Per 1,000 persons	Percent distribution	Number (000's)	Per 1,000 persons	Percent distribution	
All ages	19,875	114.9	100.0	166,935	965.2	100.0	8.4
Under 5	1,534	77.5	7.7	11,632	587.9	7.0	7.6
5 to 14	1,910	54.6	9.6	8,928	255.2	5.3	4.7
15 to 24	3,456	154.4	17.4	18,322	818.8	11.0	5.3
25 to 34	3,823	172.0	19.2	22,954	1,032.5	13.8	6.0
35 to 44	2,872	123.7	14.5	24,074	1,036.6	14.4	8.4
45 to 54	2,246	111.1	11.3	25,876	1,279.9	15.5	11.5
55 to 64	1,851	122.2	9.3	22,525	1,486.8	13.5	12.2
65 to 74	1,393	141.4	7.0	20,112	2,041.4	12.0	14.4
75 and over	790	153.7	4.0	12,511	2,434.5	7.5	15.8

[1] Hospitals in which most patients stay for less than 30 days.

Source: U.S. Department of Health, Education, and Welfare, Public Health Service, National Health Survey. Hospital Discharges and Length of Stay: Short-Stay Hospitals, United States, 1958–1960. Health Statistics Series B–No. 32, Washington, D.C., U.S. Government Printing Office, April 1962, p. 14.

Table 7. **HOSPITAL STAY: Percent Distribution of Patients Discharged and Hospital Days, by Length-of-Stay Intervals and by Age, Short-Stay Hospitals,[1] United States, 1958–1960**

Age	Length-of-stay intervals						
	Total	1 day	2 to 5 days	6 to 14 days	15 to 30 days	31 days and over	Unknown
	Percent of patients discharged						
All ages	100.0	10.9	46.9	30.6	8.0	3.3	0.3
Under 15	100.0	27.0	44.9	19.5	5.8	2.4	.4
15 to 24	100.0	9.9	65.3	21.0	2.3	1.3	.2
25 to 44	100.0	7.6	56.5	29.0	5.1	1.7	.2
45 to 64	100.0	7.4	30.6	43.4	13.2	5.2	.3
65 and over	100.0	4.1	22.6	44.1	19.4	8.7	1.1
	Percent of hospital days						
All ages	100.0	1.3	19.3	32.4	20.1	26.9	
Under 15	100.0	4.5	23.6	28.1	20.5	23.3	
15 to 24	100.0	1.9	42.9	30.9	9.4	15.0	
25 to 44	100.0	1.1	28.4	35.2	14.8	20.5	
45 to 64	100.0	.6	9.0	34.7	23.8	31.8	
65 and over	100.0	.3	5.3	28.3	28.2	37.9	

[1] Hospitals in which most patients stay for less than 30 days.

Source: U.S. Department of Health, Education, and Welfare, Public Health Service, National Health Survey. Hospital Discharges and Length of Stay: Short-Stay Hospitals, United States, 1958–1960. Health Statistics Series B—No. 32, Washington, D.C., U.S. Government Printing Office, April 1962, pp. 16–17.

Table 8. **NURSING HOMES AND RELATED FACILITIES: National Estimates by Type of Care Provided, United States and Possessions, 1961**

Primary type of care [1]	Number			Percent distribution			Average (median) size of facility
	Facilities	Beds		Facilities	Beds		
		Total	Skilled nursing		Total	Skilled nursing	
All facilities, total	23,000	592,800	362,200	100.0	100.0	100.0	20
Skilled nursing care, total	9,700	338,700	337,300	42.2	57.1	93.1	25
Personal care, total	11,100	207,100	21,500	48.3	34.9	5.9	14
With skilled nursing	1,400	83,100	21,500	6.1	14.0	5.9	29
Without skilled nursing	9,700	124,000	0	42.2	20.9	—	12
Residential care, total	2,200	47,000	3,400	9.6	7.9	.9	16
With skilled nursing	200	12,400	3,400	.9	2.1	.9	40
Without skilled nursing	2,000	34,600	0	8.7	5.8	—	14

[1] Represents the type of care provided to a majority of the residents.

Source: U.S. Department of Health, Education, and Welfare, Public Health Service, Division of Hospital and Medical Facilities. 1961 Inventory of Nursing Homes and Related Facilities. (In process.)

Table 9. **PERSONS RECEIVING PERSONAL CARE[1] AT HOME: Distribution of Persons by Age, According to Length of Time Receiving Such Care, United States, July 1958–June 1959**

Length of time under care	All ages	Age		
		Under 45	45 to 64	65 and over
	Number of persons (000's)			
All persons	1,128	245	225	658
Under 1 year	306	57	75	174
1 to 4	429	63	76	290
5 years or more	344	124	68	152
Unknown	49	1	6	42
	Percent distribution			
All persons	100.0	100.0	100.0	100.0
Under 1 year	27.1	23.3	33.3	26.4
1 to 4	38.0	25.7	33.8	44.1
5 years or more	30.5	50.6	30.2	23.1
Unknown	4.4	.4	2.7	6.4

[1] In this survey, personal care at home was defined as "family help or nursing care provided part time or full time in the person's own home either by members of the household, other relatives, friends, persons hired for the service, or by charitable or public agencies. Usual care required by infants is not included as nursing care."

Source: U.S. Department of Health, Education, and Welfare, Public Health Service, National Health Survey. Persons Receiving Care at Home, United States, July 1958–June 1959. Health Statistics Series B–28, Washington, D.C., U.S. Government Printing Office, October 1961, p. 4.

Health Personnel, United States, 1960–62

Type of health personnel	Year	Number	Per 100,000 population
Physicians, M.D. and D.O.	1962	[1] 273,770	145
Doctors of medicine (M.D.)		259,105	137
Doctors of osteopathy (D.O.)		14,665	8
Dentists	1961	[1] 103,995	56
Dental hygienists, technicians, and assistants	1960	115,000	64
Registered professional nurses (R.N.)	1960	504,000	279
Practical nurses	1960	225,000	125
Nurses' aides, attendants, and orderlies	1960	400,000	221
Social workers, medical and psychiatric	1960	11,701	6
Medical		4,494	2
Psychiatric		7,207	4

[1] Includes active and retired persons in the United States and outlying areas. All other figures are for active persons in the United States.

Sources: American Dental Association, Bureau of Economic Research and Statistics. Distribution of Dentists in the United States by State, Region, District and County. Chicago, The Association, 1962, p. 4.

Peterson, Paul Q. and Pennell, Maryland Y. Health Manpower Source Book 14, Medical Specialists. Public Health Service Publication No. 263, section 14. Washington, D.C., U.S. Government Printing Office, 1962, p. 231.

Stewart, William H., Pennell, Maryland Y., and Smith, Lucille M. Health Manpower Source Book 12, Medical and Psychiatric Social Workers. Public Health Service Publication No. 263, section 12. Washington, D.C., U.S. Government Printing Office, 1961, p. 1.

U.S. Department of Health, Education, and Welfare, Public Health Service, Division of Public Health Methods. Chart Book on Health Status and Health Manpower. Washington, D.C., September 1961, p. 28.

Appendix B

Case Studies in Community Action

Prepared by

Health Services for
Long-Term Illness Program
Division of Chronic Diseases
Public Health Service

Case Studies

St. Louis Nursing Home Project

The St. Louis nursing home project was started in 1960 under the auspices of the Health and Welfare Council of Metropolitan St. Louis, as a cooperative project with the Long-Term Illness Program of the U.S. Public Health Service. The St. Louis city and county health departments and the Missouri State Department of Health are cooperating with the Health and Welfare Council in carrying out the study.

The short-range goal is to establish criteria for services that should be provided in different types of nursing homes. These criteria will reflect the best judgments of professional persons working in the fields related to nursing homes and homes for the aged: medicine, dentistry, nursing, social services, rehabilitation, recreation, dietetics, hospital care and nursing home administration. Approximately 100 professional persons working together have served on the committees to develop the criteria.

Each participating nursing home is being studied to determine to what extent the specified services are available for or provided to their residents. A listing will be developed classifying the homes as to the services available through them. Selected characteristics will be gathered for each resident to describe the types of persons residing in the homes. This information could provide the basis for determining if significant differences exist between persons residing in sheltered care institutions and those in the general community, and would be essential in developing a consultation service for care of elder persons.

The information collected will help in planning adequate care for the aged in the community by providing means for determining such factors as:

1. The number of beds available classed by the kinds of service provided.

2. The number and kinds of additional beds needed.

3. The new services that should be developed.

4. The kinds of services that could be established through cooperative relationships between homes, and between homes and other facilities.

5. The possibilities for more closely relating potential residents' requirements to services available in homes.

The long-range goal of the study is to establish a counseling and referral service for those requesting placement in nursing homes or homes for the aged in Metropolitan St. Louis.

The project is to be carried out in three phases. The first phase involves listing the services available in each of the participating nursing homes. This

listing will be made available to each practicing physician in the St. Louis city and county health departments. Interpretation will be given to the physicians regarding the use of the list and its limitations. An attempt will be made to secure, from at least a sample of the physicians, their experience in using such a listing. The second phase will be geared to the identification of patients' characteristics. The third phase will be the creation of an information and counseling service to assist the patient, his family, and professional personnel to identify the nursing home which would best meet the individual's need for services.

Rehabilitation Evaluation Clinics

The Michigan State Department of Public Health has been cooperating with a number of local health departments during the past several years to provide rehabilitation evaluation clinics. These clinics have a twofold purpose: (1) to provide skilled professional services not now available in the communities to help local physicians plan restorative services for their chronically ill patients, and (2) to help communities find ways of helping patients obtain the type of care advised at the time of the clinic evaluation.

A clinic is scheduled only after the county health department and the county medical society have had an opportunity to make appropriate arrangements, and the local physicians have selected the patients who might best profit from evaluation by a team of professional people knowledgeable in rehabilitation.

The team staffing the clinic is composed of local practicing physicians, county health department personnel, and the following from the State Health Department: a physiatrist, a physical therapist, a medical social worker, and a nurse trained in rehabilitation nursing. Also invited to participate are representatives of community agencies that have previously served the patient.

After the clinic is held, the medical social worker remains in the community or returns to it for several days to work with the patients, their families, the patients' physicians, and community agencies to implement the treatment plan.

Many patients have been assisted in obtaining needed care utilizing, in many instances, the services of local and State agencies. A byproduct of the project has been the recruitment of a number of professional persons who already live in the areas served by the clinics.

Hospital-Nursing Home Affiliation Agreements

Studies by the Public Health Service in 1958 and 1959 revealed the need for closer relationships between hospitals and nursing homes. Investigations

and interviews with hospital and nursing home administrators indicated the following facts:

1. Hospitals and nursing homes can affiliate effectively.

2. Any affiliation of the two facilities must assure each of its autonomy and self-respect.

3. Nursing homes can offer assistance to the hospital in such areas as recreation, management of the long-term patient and his family, and special nursing techniques especially applicable to the care and management of the chronically ill patient.

4. Hospitals can provide direct service in such areas as physical therapy, laboratory, and X-ray.

5. Hospitals can furnish technical advice in such areas as nursing techniques, physical therapy, nutrition, pharmacy, plant maintenance, and medical records.

6. The referral of patients between facilities should be an integral part of affiliation agreements.

7. The active cooperation and participation of the private physicians in the community is essential to any affiliation.

8. Joint training efforts of medical and paramedical personnel should be undertaken as part of the affiliation.

Based on these findings, the Long-Term Illness Program of the Public Health Service provided financial support for 11 one-year demonstration projects of affiliations between hospitals and nursing homes in the following locations: Anniston, Ala. (2 projects); Abeline, Kans.; Muskegon, Mich.; Hastings, Nebr.; Flemington, N.J.; Ridgewood, N.J.; Las Cruces, N. Mex.; Tulsa, Okla.; and Harrison, Va. (2 projects). The first contract in this series was signed in August 1960, with the affiliating institutions in Anniston. The final contract in the series was signed in July 1961.

These affiliations have resulted in mutual benefits to the hospitals and nursing homes. The most important advantage to the hospitals in most of the project areas is the freeing of beds by the transfer of long-term patients who, while needing services, do not require the full range of services available in the hospital. Currently referrals average about 10 to 15 per month per project.

Many of the hospitals arrange for their student nurses (professional and practical) to get first hand experience in the management of geriatric patients through brief service in the nursing home. Interns and general practice residents in one project serve as supervising physicians to the nursing homes involved. In another project, nursing home personnel help to teach the hospital personnel how to manage bedsores by using the new "sheepskin method."

Nursing homes have increased requests for consultative services. This has been particularly marked in nutritional consultations. In one project, the nutritionist spends an average of four hours a week in the nursing home. During this period she helps plan menus, assists with food purchasing, and gives classes on recipe standardization, tray arrangement, feeding, and other dietary matters.

In another project, the hospital building superintendent spends one day a month with the nursing home administrator to discuss repairs, alterations, and housekeeping problems. The administrator also participates in the monthly training session for employees of the hospital maintenance staff.

In a number of projects, the hospital physical therapist not only provides direct service to patients, but also teaches the staff of the home to carry out many simple restorative techniques.

An indication of the effectiveness of hospital-nursing home relationships is that to date three contracts have expired, and all three locations are continuing with the affiliations without additional Federal support. In two locations the affiliations are expanding to include additional facilities in outlying areas.

Creation of a Chronic Disease Facility as Part of an Acute General Hospital

The Jewish Hospital of Saint Louis

In the early postwar years, many health agencies looked for ways to renew their services to the community in terms of program, personnel, and physical facilities. This was true of the health agencies under Jewish auspices in the St. Louis area. In competition for community resources to expand their individual programs were: the Jewish Hospital of Saint Louis, a 298-bed institution for the acutely ill; the Miriam Rosa Bry Convalescent-Rehabilitation Hospital, a 31-bed facility; the Jewish Sanitorium, an 81-bed chronic disease hospital; the Jewish Orthodox Old Folks' Home, a 130-bed home primarly for the well aged; and a medical social service bureau.

Studies performed under the auspices of the Jewish Federation of St. Louis during the late 1940's resulted in a coordinated community health plan that emphasized the need to care for the chronically ill patient. This plan called for corporate merger of the hospital, the chronic disease and rehabilitation facilities, and the medical social service agency. It further called on the home for the aged to expand its services to include infirmary care of its aged residents who became ill and to include a preventive health program; this extension of services would be supervised by the hospital.

Implementation of this integrated health plan began in 1951; the necessary organizational and physical structure changes needed to carry out the plan continued through 1956. A building program increased the size of the general

hospital from its original 298 beds to over 500 beds to accommodate the needs of the old rehabilitation and chronic disease hospitals as well as to provide additional facilities for acutely ill patients and new inpatient adult and child psychiatry units. At the same time, an infirmary was constructed at the home for the aged to provide care for patients who became ill at that institution. The hospital provided a medical director for that facility and worked closely with the old folks' home in providing assistance in medical, nursing, institutional, and other problems, an arrangement that has continued to the present.

Another patient care element paralleled these developments. An organized home care program was instituted in 1952 caring for 25 patients initially and gradually expanding to 60 patients. This extension of hospital services carried intramural programs into the homes of patients needing this level of care.[1]

As a result of this community plan, all medical and hospital services have been centralized under one administration geared to providing a wide spectrum of services. The hospital's chronic disease program, which benefited greatly from these developments, has shown progressively better results over the years since physical merger took place.

Because of superior resources of personnel, equipment, and physical plant, the services rendered to chronic disease patients[2] tend to be more comprehensive and of higher quality when incorporated in the organic envelope of the general hospital than when provided by an independent chronic disease institution. There have been significant increases in the numbers and types of laboratory tests, X-ray examinations, and electrocardiographic procedures. An increased number of patients have been discharged to their own homes and, hence, have not become a permanent drain on community health resources. The death rate has dropped from over 80 percent in the former separate chronic hospital to a current figure of 31 percent in the chronic division of the general hospital. The average length of stay has decreased from more than 600 days to 140 days. The autopsy rate has risen from zero to 30 percent. While the costs of providing these services are not as high as in the acute short-term portion of the hospital, they are substantially higher than costs in nursing homes or institutions offering only domiciliary services.

This merger of many facilities and skills has reinforced the traditional goal of the hospital in caring for the acute short-term patient and has added effective new programs for the care of the long-term patient.

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[1] Littauer, David, M.D.; Flance, I. Jerome, M.D.; and Wessen, Albert F., Ph. D., *Home Care*, Chicago; American Hospital Association, 1961. (Item 35 in appendix C, Selected Bibliography.)

[2] Littauer, David, M.D.; Steinberg, Franz U., M.D.; and Gee, David A., *A Chronic Disease Unit in a General Hospital: Analysis of Five Years Operating Experience*, St. Louis: Medical Care Research, 1962. (Submitted for publication.)

Central Information, Referral, and Counseling Services

Central Service for the Chronically Ill of the Institute of Medicine of Chicago

The forerunner of the present-day central information, referral, and counseling programs in operation throughout the Nation is the Central Service for the Chronically Ill of the Institute of Medicine in Chicago, instituted in January 1944 under the financial sponsorship of the Community Fund.

For the first 10 years of the program, along with the operation of an information and counseling service, major emphasis was placed on the collection of communitywide data on the needs of the chronically ill, the formulation of standards, and the development and promotion of a plan to meet community needs. By 1954, the major community problems of chronic illness had been identified and clarified. Information had been collected on the types and extent of additional services and facilities needed; the advantages and disadvantages of various methods of organizing these services; and on costs, and possibilities for financing. Upon completion of these tasks, the initial objectives of the program were achieved. This brought to a close the temporary purposes for which the center had been established.

The need was apparent, however, for continuation of referral and counseling services to individual patients and for guidance and consultation to facilities caring for these patients, particularly private nursing homes. With financial help from the Chicago Medical Society, Community Fund, Chicago Community Trust, Illinois Division of the American Cancer Society, the Chicago Heart Association, and some private foundations, the center was established on a permanent basis in the Institute of Medicine.

The major problems of Chicago's chronically ill, as evidenced by requests to the central service and by its extensive fact finding work in the community, were found to be a need for the following: (1) substantial improvements in financial services; (2) improvement in the quality of long-term care facilities; (3) a broader range of services including rehabilitation services within the various long-term institutions; (4) additional and improved services to help patients and their families at home; and (5) closer coordination of the activities of the many different organizations involved in planning and developing community services in the field of chronic illness.

The Chicago program, along with pioneering programs in San Francisco, Milwaukee, Cleveland, and Essex County, N.J., provided valuable guidelines to current efforts to develop central information, referral, and counseling services. New programs vary greatly in format and are being conducted under the auspices of various types of agencies. Descriptions of three programs created within the past few years follow.

An information, counseling, and consultation center was established in the fall of 1961 under the auspices of the Mansfield (Ohio) Memorial Homes, Inc., as a project of the Division of Chronic Diseases of the Public Health Service. The project is designed to develop better utilization of existing community facilities and the various health, social, and recreational agencies. Cooperating agencies include: the city, county, and State health departments; the Medical Advisory Committee of the Geriatric Center of Mansfield Memorial Homes, Inc.; and the Liaison Medical Committee to Mansfield General Hospital, through both its medical staff and administration.

Mansfield Memorial Homes, Inc., is a private foundation which serves a city-county area having a population of approximately 100,000, divided about equally between the city and the remainder of the county.

To date, the foundation has established a small home for the aged, a day center providing a variety of services, a drop-in center for the downtown area, a Meals-on-Wheels program, and professional consultation services on leisure-time needs of nursing home patients.

A geriatric center, expected to be available early in 1963, will be operated under the auspices of Mansfield Memorial Homes, Inc. This center will provide modern nursing home beds with a full range of professional services for both inpatients and outpatients. A counseling project will be located at this center to facilitate evaluation of persons needing either inpatient or outpatient services. It is anticipated that local hospitals, the health department, and practicing physicians will make referrals to the geriatric center.

At the outset of this program, the services available for the chronically ill and aged in the community were identified, visited, and evaluated from the standpoint of scope of services provided for the elderly.

The project is staffed by a medical social worker, who is supervised by the director of the Mansfield Memorial Homes. The social worker is responsible for the following activities:

1. Consulting physicians who treat older people in Greater Mansfield.

2. Developing records on each request for service and the kinds of service given.

3. Consulting existing public and private agencies to identify all service gaps.

4. Consulting and assisting patients, families, and agencies, including the development of medical and social plans patterned to individual needs.

5. Evaluating the effect of coordinated use of resources on patient and family, both before the completion of the new geriatric center and after its added services are available.

6. Developing appropriate training institutes for physicians and paramedical and social welfare professions.

7. Determining how the professions will use existing and newly developed services, and implementing the findings.

This project is in a community where an active leadership group is interested in developing the range of services and facilities needed by older individuals. Some housing for older individuals may be needed to round out the present scope of services.

Information Services for the Chronically Ill and Aged

A 3-year pilot project to develop an information, referral, counseling and consultation service for the chronically ill and aged was established in January 1959 in Providence, R.I., under the direction of the Rhode Island Council of Community Services. The project was financed by a Public Health Service grant, with additional support from the Rhode Island Department of Health,

Project objectives were:

1. To achieve better utilization of existing services.

2. To identify gaps in community facilities and services.

3. To determine the need for designing new patterns of service for the chronically ill and aged.

The staff consisted of a full-time professional consultant experienced in medical social work and a full-time secretary-receptionist. The staff consultant worked under the administrative direction of the Executive Director of the Rhode Island Council of Community Services, Inc., with professional consultation as needed from the staff of the Rhode Island Department of Health, and technical consultation from the staff of the Division of Chronic Diseases, Public Health Service. An advisory committee was also created.

The project served a sizeable number of chronically ill and aged individuals and provided information and advice regarding resources to many individuals and agencies. Consultation was given to help agencies better meet the health-related needs of individuals.

The final report on the project had this observation:

> In retrospect, the Information Service has reached chronically ill and aging persons in all parts of the State of Rhode Island, but predominantly those in the central metropolitan area. In the first year, direct service to persons in need was highlighted. The consultation aspect was broadened during the second year. The third year crystallized the implications for program planning. Gaps in service have been documented; work with agencies broadened. It was during the third year that the Council Board set up the Chronic Illness Committee which is interested in furthering the community's efforts at program development to meet the problem of chronic illness—the Homemaker Service Project, the Public Health Nursing Study, which became the basis for the Southern Health District Project (public health nursing for the chronically ill), the Dexter Manor Project (health maintenance for the aging in a public housing development for the aging). Because these projects have broad implications for service to chronically ill persons and were given impetus by the Council, it is clear

that Information Service can provide the connective tissue between the various projects and the network of community services by virtue of its wealth of information. It serves as a sensitive barometer for documenting need for services for the chronically ill and aging.

At the completion of its three-year existence as a demonstration project, the Information Service was established as a permanent community information service financed by the State health department and several voluntary health agencies.

Chronic Illness Center

The Chronic Illness Center of Cuyahoga County, Ohio, was established in January 1962 by the County Commissioners under the County Hospital Board as a result of cooperative study and endeavor by the County Coordinator of Chronic Illness, the Academy of Medicine (County Medical Society), the Committee on Chronically Ill, Health Council, Welfare Federation, and the six health officers within the county.

Its functions are:

- To establish an information, receiving, referral, and replacement center, located in a central community facility, to be the focal point for accepting any chronically ill person, referred by self, physician, hospital, social agency, etc., for the purpose of providing information, consultation, screening and referral to, or placement in, a facility, public or voluntary, whether for more intensive medical evaluation or for care and treatment.

- To compile statistical and other records, and provide a laboratory for social research.

- To develop a cooperative relationship with community facilities, public and voluntary, and including acute and chronic hospitals, nursing homes, home care programs, etc., so that placement can be assured and coordination facilitated.

The information and referral part of the program is underway. A citizens' Steering Committee and a professional Medical Advisory Committee have been formed and are working on the development of other functions. An inpatient-outpatient diagnostic unit is planned for Metropolitan General Hospital with a direct tie-in to the Center. Cooperative arrangements with other facilities are being developed.

Under consideration by the Center staff are the following:

- Plans for more rapid placement of patients and for more efficient transfer from institution to institution as individuals' needs change.

- Increased community planning for the services that enable patients to stay in their own homes, i.e., extension of organized home care, Meals-on-Wheels and homemaker programs.

- Increased social counseling oriented to the chronically ill.

- Work with other community groups on: 1) improved training in long-term care for health personnel; 2) broader public education in prevention and rehabilitation; 3) development of better nursing homes and adequate public financing of nursing home care for the indigent.

Appendix C

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Appendix D

Glossary of Terms

The following list of terms is provided to larify their meaning within the context of this eport. The language is descriptive rather than egalistic and is not intended to substitute for xisting statutory or regulatory definitions. ome of the terms, as presently used, describe inds of institutions or programs that are undergoing rapid change, both in purpose and function; therefore, some definitions may have only transitory validity.

Although the term "institution" is often used interchangeably with the term "facility," institution as used in this glossary refers not only to the physical plant but also to the services provided in it.

Planning and Related Concepts

reawide Planning

Areawide planning is the continuing proc- ss through which hospitals and related health acilities and services coordinate their planning ithin a designated geographical area. This rocess is facilitated through the areawide ealth facility planning agency, which has esponsibility for: (1) preparation of profiles f area resources and needs; (2) cooperative ctivities with public and private financing and lanning agencies; (3) consultation in each hase of health facility planning; and (4) eval- ation of planning proposals in the light of stablished criteria.

Coordination of Services

Coordination of services is a continuing process through which health services and programs achieve a harmonious functional relationship, with the objective of making all resources readily available to patients without unnecessary duplication of services.

Continuity of Care

Continuity of care is the result of a planned treatment program designed to provide the individual with the total range of needed services under continuing responsible direction.

The Patient

ong-Term Patient

A long-term patient is an individual who, ecause of physical or mental illness, deteriora- on or disability, requires medical, nursing, r supportive health care for a prolonged period of time. Also included in this category is the individual who, because of severity of acute illness or injury, or resulting complications, requires an extended period of convalescence or treatment.

Institutions

Hospital

A hospital is an institution that has an organized medical staff and provides facilities and services primarily for inpatient care of individuals who require definitive diagnosis and treatment for illness, injury, or other disability, and that also regularly makes available at least clinical laboratory services, diagnostic X-ray services, and facilities for definitive clinical treatment.

Chronic Disease Hospital

A chronic disease hospital is an institution that has an organized medical staff and provides facilities and services primarily for long-term inpatient care of individuals who require diagnosis and/or treatment for illness, injury, or other disability, and that also regularly makes available at least clinical laboratory services, diagnostic X-ray services, and facilities for clinical treatment.

Nursing Home

A nursing home is an institution providing facilities and services primarily for inpatient care of individuals who require skilled nursing care and related medical services, but who do not require hospital care, with these services being prescribed by and performed under the general direction of persons legally authorized to practice medicine or perform surgery.

Shelter Home for the Aged

A shelter home for the aged is an institution providing congregate living arrangements for aged individuals who require primarily custodial and personal services, but who do not require skilled nursing care and related medical services.

Geriatric Home for the Aged

A geriatric home for the aged is an institution providing facilities and services for coordinated social, medical, and rehabilitative care for aged individuals who may require not only custodial and personal services, but who also may require skilled nursing care and related medical services or diagnosis and intensive treatment.

Rehabilitation Center

A rehabilitation center is an institution providing facilities and services—medical, phychological, social and vocational—for physically or mentally disabled individuals who require a coordinated treatment program designed to develop or restore maximum functional capacity.

Night Hospital

A night hospital is an institution having an organized medical staff and providing facilities and services for individuals whose needs can be met by specialized inpatient care at night. This type of care represents an intermediate stage between continuous inpatient care and relatively independent community living.

Programs and Services

Day Care Program

A day care program is one having an organized professional staff that provides diagnostic and/or treatment services for individuals whose needs can be met by a limited number of hours of specialized care during the day, but who do not require inpatient care. This type of care represents an intermediate state between inpatient care and relatively independent community living.

Rehabilitative Services

Rehabilitative services comprise those activities and procedures designed to assist a physically or mentally disabled individual to achieve or maintain the highest attainable level of function through an evaluation and treatment program which provides—under physician direction—one or a combination of medical, paramedical, psychological, social, and vocational services, determined by the needs of the patient.

Skilled Nursing Services

Skilled nursing services are available when provided by or under direct supervision of registered professional nurses and involve planning and executing nursing care in accordance with the orders and instructions of the attending physician.

Personal Care

Personal care includes general supervision of and direct assistance to individuals in their daily activities, such as getting in and out of bed, bathing, dressing, eating, and walking. It also includes supervision of medications that can be self-administered.

Shelter Care

Shelter care is the provision, to individuals who are essentially able to manage the normal activities of daily living, of such services as room, board, laundry and general supervision with only occasional assistance. These services are found primarily in homes for the aged, foster homes, boarding homes, and other facilities for congregate care.

Home Care

Home care is the provision of health and/or supportive services in the home to individuals who are ill or disabled, but who do not require institutional care.

Coordinated Home Care Program

A coordinated home care program is one that is centrally administered and that, through coordinated planning, evaluation, and follow-up procedures, provides for physician-directed medical, nursing, social and related services to selected patients at home.

U.S. GOVERNMENT PRINTING OFFICE:1965